COUNTY COUNCIL OF CUMBERLAND

Annual Report

ON THE

HEALTH SERVICES OF THE COUNTY

For the Year 1953

KENNETH FRASER,
M.D., F.R.S.E., D.P H., D.T.M.,
COUNTY MEDICAL OFFICER.

INDEX

TO THE CHAIRMAN AND MEMBERS OF THE CUMBERLAND COUNTY COUNCIL

Mr. Chairman, My Lord, Ladies and Gentlemen,

I beg to present the annual report on the Health Services for 1953.

Vital Statistics

The vital statistics for 1953 for the most part show little change from the previous year.

Perhaps the most important point to note is that the deaths from pulmonary tuberculosis, to which reference is made later in this report, have remained almost exactly at the same figure as in 1952. The 1952 figure was by far the lowest on record, and the maintenance of this figure therefore gives some grounds for satisfaction, but it is regrettable that this county has not shared in the general fall of deaths from pulmonary tuberculosis which occurred over the country as a whole during 1953.

The other point which calls for comment is the rise in the number of maternal deaths, to which reference is also made later in the report, to a figure approximating the yearly average of a number of years ago when puerperal sepsis, now I suppose we may say almost non existent, made a substantial contribution to the maternal mortality.

Problems for 1954

I have never felt that annual reports should be too strictly limited to the calendar years to which they refer, and I think it is always useful to make some reference to current problems. I think we may say that the problems for 1954 are three in number.

1. *B.C.G. Vaccination.*

Prolonged discussions have taken place with the Consultant Chest Physicians on this matter which arises out of the authority conveyed in the Ministry's circular (22/53) issued in November, 1953, to institute Mantoux testing and B.C.G. vaccination of children in the 13 year old group. Our newly appointed Deputy County Medical Officer, Dr. Minto, has actually been carrying out Mantoux testing and B.C.G. vaccination

in this age group in Cornwall and that should be a great help. It must, of course, be realised that the carrying out of this work in a scattered rural county like Cumberland is far from easy. It will have to be arranged with as little disruption of school time as can possibly be arranged. The alternatives are to carry out the work in the larger schools or to bring the children to our clinics. The first alternative impinges primarily on accommodation, and the second on school time because of the travelling involved.

It has been reluctantly agreed that the start on Mantoux testing and B.C.G. vaccination of the 13 year old group must be deferred until the spring of 1955. The reason is our present shortage of medical staff qualified to undertake this work which position will be rectified towards the end of the year. It is proposed, however, to strike out on our own line in this county in this matter by an important preliminary step.

The proposal is that we should undertake, with the consent of the parents, the Mantoux testing of between 3,000 and 4,000 children in the 5 and 6 year old groups during the autumn of 1954. This proposal has the warm approval of the Consultant Chest Physicians who feel that it would give them invaluable information about the incidence of tubercle, often unsuspected, in the areas selected.

So far as is practicable examination by mass miniature radiography will be brought into the picture, and it is hoped that during 1955 there may be a substantial extension of mass miniature radiography among the leaver group of children from 14 years of age upwards. I am quite sure that it would be desirable, if it can be arranged, to include examination of children by mass miniature radiography as a routine part of school medical inspection, certainly in the leaver group. One of the difficulties may lie in the question of transport.

2. *Distribution of Welfare Foods.*

Responsibility for this has been placed on the shoulders of local health authorities as a matter of national policy on the closing down of the Ministry of Food. The average volume of distribution of these welfare foods, chiefly national dried milk, orange

juice, cod liver oil, and vitamins, in this county amounts to about 300,000 items per annum. No doubt this figure will be small compared with a number of other counties and with large cities with a greater population than ours. Nevertheless, in a rural county the problem lies not in the gross turnover, but in the number of distribution points. In this county there are 109 distribution points.

Distribution to the callers collecting these welfare foods takes place weekly, and the instructions are that arrangements should be made so far as possible to ensure that the new lines of distribution are not less convenient to the public than those at present operating. Questions of storage, the arrangements for new distribution centres, and staffing arise. The required records are complicated, and taken all in all the task is considerable.

Given reasonable time the problems outlined above would not have presented any great difficulty in their solution. In fact we only got about 6 to 8 weeks' warning and this was not reasonable. Nevertheless, I trust that long before this report is in your hands the transfer will have been smoothly effected.

The county branch of the Women's Voluntary Services who have hitherto been closely concerned with this matter have agreed to undertake the distribution at 101 of the above centres, and may, in due course, take over one more. Our great indebtedness to the County Organiser and to her fellow-workers in the distribution of these welfare foods is therefore apparent. It is clear also that we will be indebted to many private individuals, who from shops, post offices, or private houses in the rural areas, have been undertaking, and will, we are assured, continue to undertake, the distribution of these welfare foods in their villages on a voluntary basis as a community service.

3. *Co-operation between general practitioners and health visitors.*

The British Medical Association in March of this year issued a memorandum under the title "The General Practitioner and the Health Visitor" drawn up by a joint sub-committee of the General Medical Services and Public Health Committee of the British

Medical Association and approved by these committees and by the council of the Association. This memorandum emphasises the importance of " the closest co-operation between general practitioners and health visitors," and in effect urges general practitioners, medical officers of health and health visitors " to work in partnership towards that co-operation which will ensure efficient and all-embracing care for the patient whatever his age or state of health." This gesture by the British Medical Association is more than welcome, and I am certain it is safe to say that those of us who are concerned in the matter from the local health authority standpoint will do our utmost to see that the recommendations of the British Medical Association do not prove abortive through any failure on our part. Plans are in hand for setting up an experimental area in the county where these new arrangements can be tried out.

Blood Testing of Expectant Mothers

Reference is made elsewhere in this report to this most important matter and what we are doing about it. A short reference is also made in the report to the care of spastics, that is to say persons suffering from the effects, in one form or another, of cerebral palsy. Recently all the seriously affected spastic children in the county were reviewed and it emerged that out of this small group of 8 children 3 were Rhesus babies. I hope the significance of this will not be overlooked by those concerned. In this alone, even if for no other reasons, and there are plenty, lies the justification for close and continued interest in this matter.

New Syllabus for Student Nurses

The General Nursing Council have recently revised the syllabus for student nurses in training and they have included in the syllabus a series of 4 lectures on social medicine, the intention of which is clearly to bring the nursing training in hospital into some contact with public health work on the social side outside hospital. This means learning to appreciate what is meant by aftercare on discharge from hospital in such matters as concern local health authorities, and the intention also is that these student nurses should have an opportunity of doing some domiciliary visiting with the health visitors or district nurses and should have

an opportunity of seeing our various types of clinics in action. These matters have been arranged by this department and the East and West Cumberland Hospital Management Committees.

Staff

Dr. James L. Gilloran, Deputy County Medical Officer, resigned his appointment towards the end of the year on appointment as Senior Depute Medical Officer of Health for Edinburgh.

Miss E. M. Rawle was appointed to a vacancy on the speech therapy staff.

Thanks

I have to record my thanks to the members of my staff for the way in which they have carried out their share of the work of the department during the year. I am grateful to the members of the Council, and especially to the Chairman and members of the Health Committee and its sub-committees for their active and continuing interest in all branches of the work.

I am, my Lord, Ladies and Gentlemen,
Your obedient Servant,
KENNETH FRASER,
County Medical Officer.

County Health Department,
11, Portland Square,
Carlisle.

June, 1954.

STATISTICAL AND SOCIAL CONDITIONS OF THE AREA

The essential vital statistics for the year 1953 are as under:—

Population

	At 1951 Census.	Estimated by Registrar General Mid. 1953
Urban Districts	86,335	... 86,780
Rural Districts	131,118	... 129,320
Administrative County ...	217,453	... 216,100

Population of Sanitary Districts, 1953

Urban Districts		
Workington	28,800	
Whitehaven	24,940	
Maryport	12,580	
Penrith	10,470	
Cockermouth	5,250	
Keswick	4,740	
		86,780
Rural Districts		
Border	30,070	
Ennerdale	28,380	
Wigton	23,410	
Cockermouth	19,350	
Millom	14,370	
Penrith	11,450	
Alston	2,290	
		129,320
Total for Administrative County ...		216,100

Rateable Value and sum represented by a penny rate.

The rateable value of the County at 1st April, 1953, was £1,127,930. The estimated product of a penny rate was £4,312.

Extracts from vital statistics for the year 1953

LIVE BIRTHS

	Total Births	Males	Females
Legitimate	3,484 ...	1,772 ...	1,712
Illegitimate	124 ...	53 ...	71
Total	3,608 ...	1,825 ...	1,783

Birth Rate per 1,000 population 16.7 (England and Wales 15.5).

STILL BIRTHS

	Total Still-Births	Males	Females
Legitimate	95 ...	49 ...	46
Illegitimate	4 ...	4 ...	—
Total	99 ...	53 ...	46

Rate of Still-Births per 1,000 total births 27.

DEATHS

Total Deaths	Males	Females
2,571	1,341	1,230

Crude Death Rate per 1,000 population 11.9
(England and Wales 11.4)

DEATHS FROM DISEASES AND ACCIDENTS OF PREGNANCY AND CHILDBIRTH.

Pregnancy, Childbirth and abortion 5

Maternal Death Rate per 1,000 Total Births—1.34

DEATH RATE OF INFANTS UNDER ONE YEAR OF AGE.

All Infants per 1,000 Live Births 27
Legitimate Infants per 1,000 Legitimate Live Births 26
Illegitimate Infants per 1,000 Illegitimate Live Births 40

DEATHS FROM CANCER (ALL AGES) 352

DEATHS from MEASLES (ALL AGES) ... ... —

DEATHS FROM WHOOPING COUGH (ALL AGES) ... —

DEATHS FROM GASTRITIS, ENTERITIS AND DIARRHOEA (Under 1 Year) 1

The 3,608 live-births were distributed among the Urban and Rural Districts as follows:—

Births, 1953.

Urban Districts	Total Births	Legitimate	Illegitimate	Birth Rate
Cockermouth	82	82	—	15.6
Keswick	43	41	2	9.1
Maryport	223	215	8	17.7
Penrith	162	154	8	15.5
Whitehaven	528	504	24	21.2
Workington	477	459	18	16.6
Aggregate of Urban Districts	1,515	1,455	60	17.5
Rural Districts.				
Alston	37	36	1	16.2
Border	425	412	13	14.1
Cockermouth	285	281	4	14.7
Ennerdale	504	485	19	17.8
Millom	241	233	8	16.8
Penrith	188	183	5	16.4
Wigton	413	399	14	17.6
Aggregate of Rural Districts	2,093	2,029	64	16.2

The 2,571 deaths were distributed among the Urban and Rural Districts as follows:—

Deaths, 1953.

Urban Districts	Total	Males	Females	Crude Death Rate
Cockermouth	62	28	34	11.8
Keswick	52	28	24	11.0
Maryport	150	69	81	11.9
Penrith	128	63	65	12.2
Whitehaven	303	155	148	12.1
Workington	331	181	150	11.5
Aggregate of Urban Districts	1,026	524	502	11.8
Rural Districts				
Alston	22	10	12	9.6
Border	377	193	184	12.5
Cockermouth	232	121	111	12.0
Ennerdale	341	201	140	12.0
Millom	154	80	74	10.7
Penrith	116	57	59	10.1
Wigton	303	155	148	12.9
Aggregate of Rural Districts	1,545	817	728	11.9

Causes of Death.

	No. of Deaths.
Heart disease	923
Vascular lesions of nervous system	377
Cancer	352
Bronchitis	89
Tuberculosis—respiratory	44
Tuberculosis—other	4
Other circulatory diseases	105
Pneumonia	73
Influenza	35
Hyperplasia of prostate	20
Motor vehicle accidents	23
All other accidents	82
Nephritis and nephrosis	23
Congenital malformations	21
Gastritis, enteritis and diarrhoea	12
Diabetes	20
Other diseases of respiratory system	28
Ulcer, stomach and duodenum	33
Suicide, homicide and operations of war	21
Acute poliomyelitis	1
Syphilitic disease	6
Meningococcal infections	2
Other infective and parasitic diseases	10
Leukaemia	6
Pregnancy, childbirth, abortion	5
Other defined and ill-defined diseases	256

Infantile Mortality.

Of the 3,608 live births during the year, 97 infants died before reaching the age of 12 months. The infant death-rate per thousand live births is 27 compared with 32 for 1952. The figure for England and Wales is 26.8.

Causes of Death.

	No. of Deaths.
Tuberculosis—other	1
Influenza	1
Pneumonia	29
Bronchitis	1
Gastritis, enteritis and diarrhoea	1
Congenital malformations	16
Other defined and ill-defined diseases	44
Accidents	3
Other infective and parasitic disease	1
	97

Of the above 97 deaths among infants under the age of twelve months, 70 represented deaths of infants within the first 28 days, of which 32 were premature births. Reference is made elsewhere in this report to the question of prematurity.

The distribution of deaths by sanitary districts is shown in the following table:—

Urban Districts	No. of Infant Deaths	Rate
Maryport	8	35.9
Whitehaven	16	30.3
Penrith	4	24.7
Workington	14	29.3
Cockermouth	3	36.6
Keswick	1	23.3
Aggregate of Urban Districts	46	30.0
Rural Districts.		
Millom	5	20.8
Cockermouth	8	28.1
Alston	2	54.0
Wigton	9	21.8
Ennerdale	13	25.9
Border	8	18.8
Penrith	6	31.9
Aggregate of Rural Districts	51	24.4

1953 Rate for England and Wales ... 26.8
1953 Rate for Cumberland County ... 27.0

In accordance with the wishes of the Ministry, lists are appended "A" of the committees which are concerned with matters of public health, and "B" of the medical, dental, nursing and other technical staff, and the senior officers dealing with administration.

A. List of Committees concerned with matters of public health.

HEALTH AND HOUSING COMMITTEE

Dickinson, R. F. (Chairman).

Appleby, Mrs. E. (Vice-Chairman)

Bland, T. P.
Cain, Mrs. E. G.
Curwen, Mrs. J. N. St. G.
Douglas, J.
Fearon, W.
Herdman, J. F.
MacGillivray, Dr. A. G.
McCann, Rev. F. K.
McCarron, J. H.
McKeating, Mrs. B. O.
McPoland, Mrs. F.
Mitchell, J.
Nixon, W. G.
Powers, J. E.
Skelton, E. B.
Smith, Mrs. M.
Waddell, W.
Wilson, D. G.
Wright, T.
Young, T.

Ex-Officio members

Edmonds, C.
Gaskarth, F. G.
Roberts, C. H.

External members

Braithwaite, Dr. J.
Brown, Mrs. J. C.
Campbell, Miss P. H., M.B.E.
Eves, A. J., M.P.S.
Faulds, Dr. J. S.
Ferguson, Dr. T. T.
Fletcher, Dr. A. F.
Graham, Miss E. R.
Hasell, Mrs. G.
Hodgson, Mrs. H. L.
James, Mrs. E. L.
Jolly, Dr. G. M.
McCowan, R. D.
Robertson, Dr. H.
Shepherd, Mrs. W.

HEALTH GENERAL PURPOSES SUB-COMMITTEE

External members

Campbell, Miss P. H., M.B.E.
Brown, Mrs. J. C.

MENTAL HEALTH SUB-COMMITTEE

External members

Braithwaite, Dr. J.
Campbell, Miss P. H., M.B.E.
Ferguson, Dr. T. T.
Shepherd, Mrs. W.

HEALTH (EASTERN) AREA SUB-COMMITTEE

External members

Brown, Mrs. J. C.
Eves, A. J., M.P.S.
Hodgson, Mrs. H. L.
James, Mrs. E. L.

District Council Representatives

Alston R.D.C. ...	1	Penrith R.D.C. ...	1
Border R.D.C. ...	2	Penrith U.D.C. ...	1
Keswick U.D.C. ...	1	Wigton R.D.C. ...	2

HEALTH (WESTERN) AREA SUB-COMMITTEE

External members

Campbell, Miss P. H., M.B.E.
Ferguson, Dr. T. T.
Graham, Miss E. R.
McCowan, R. D.

District Council Representatives

Cockermouth R.D.C. ...	1	Millom R.D.C.	1
Cockermouth U.D.C. ...	1	Whitehaven B.C.	2
Ennerdale R.D.C. ...	2	Workington B.C.	2
Maryport U.D.C. ...	1		

JOINT (HEALTH AND EDUCATION) SUB-COMMITTEE

Health Committee Representatives

Appleby, Mrs. E.
Curwen, Mrs. J. N. St. G.
Dickinson, R. F.
Roberts, C. H.
Waddell. W.
Wilson, D. G.

Education Committee Representatives

Clayton, Rev. F. C.
Edmonds, C.
Gorley, Mrs. G. B.
Gilbertson, J. W.
Wilson, Major F. G.

*AMBULANCE SERVICE SUB-COMMITTEE

*HEALTH CENTRES AND CLINICS SUB-COMMITTEE

*NURSING SUB-COMMITTEE

External members

Brown, Mrs. J. C.
Campbell, Miss P.H., M.B.E.
Graham, Miss E. R.
Hasell, Mrs. G.
Hodgson, Mrs. H. L.
James, Mrs. E. L.

*WELFARE SUB-COMMITTEE

Broadbent, C. W.
Clayton, Rev. F. C.
Douglas, J.
Edmonds, C.
Gilbertson, J. W.
MacInnes, Miss J. E.
McCarron, J. H.
McKeating, Mrs. B. O.
Skelton, E. B.
Smith, Mrs. M.
Young, T.

*The following are ex-officio members of these sub-committees.

Appleby Mrs. E.
Dickinson, R. F.
Roberts, C. H.

SEWERAGE AND WATER SUPPLY SCHEMES

Roberts, C. H. (Chairman)
Bowness, W.
Coulthard, J.
Edmonds, C.
Gaskarth, F. G.
Holliday, R.
Kyle, W. C.
McCann, Rev. F. K.
Morton, Lt.-Col. R.
Powers, J. E.
Skelton, E. B.
Wharton, J. W.
Wilson, Major F. G.

The Children's Committee are also concerned with public health matters in respect of the care and supervision of neglected, ill-treated or abandoned children.

B. STAFF EMPLOYED DURING 1953

MEDICAL OFFICERS

County Medical Officer—

Kenneth Fraser, M.D., F.R.S.E., D.P.H., D.T.M.	Administrative.

Deputy County Medical Officer—

James L. Gilloran, M.B., Ch.B., D.P.H. (Resigned 31st October, 1953)	Administrative and clinical.

Medical Officers in Mixed Appointments—

John R. Hassan, M.B., Ch.B., D.R.C.O.G., Also Medical Officer of Health, Alston R.D.C. (In general practice)	Clinical.
James L. Hunter, M.B., Ch.B., D.P.H. (Also Medical Officer of Health Workington Borough. (Senior Assistant County Medical Officer, West Cumberland)	Administrative and clinical.
Isaac S. Jones, M.R.C.S., L.R.C.P., D.P.H. Also Medical Officer of Health Wigton R.D.C. and Penrith U.D.C.	Clinical.
Charles A. Mason, M.B., Ch.B., D.P.H. Also Medical Officer of Health Cockermouth R.D.C., Cockermouth U.D.C., and Keswick U.D.C.	Clinical.
Ethel A. Perrott, M.D., B.S., D.P.H. Also Medical Officer of Health Millom R.D.C.	Clinical.
Kenmure J. Thomson, M.B., Ch.B., D.P.H. Also Medical Officer of Health Border R.D.C., and Penrith R.D.C.	Clinical.

Assistant County Medical Officers—

Whole-Time

James E. Gallagher, M.B., B.Ch., B.A.O. L.M., D.C.H.	Clinical.
Frederick V. Jacques, M.B., Ch.B., D.P.H., D.T.M. & H. (Died 18th March, 1954)	Clinical.
Gladys J. G. Lowe, M.R.C.S., L.R.C.P. (Resigned 26th April, 1954)	Clinical.

Part-Time

Lucy M. C. Duncan, M.B., Ch.B., D.C.H., D.P.H. (Resigned 10th February, 1954)	Clinical.

Note: "Clinical duties" include school medical inspections, school clinics, and child welfare clinics.

DENTAL OFFICERS

Senior Dental Officer—

A. C. S. Martin, L.D.S.	Administrative and Clinical.

Assistant Dental Officers—

J. Askew (Died August, 1953)	Clinical.
I. R. C. Crabb, L.D.S.	
Mrs. A. M. E. Ferguson, L.D.S. (Resigned 31st March, 1954)	
D. H. Hayes, L.D.S.	
Mrs. M. Hayes, B.D.S.	
D. C. Lamond, L.D.S.	
R. B. Neal, M.B.E., L.D.S	
A .R. Peck, L.D.S.	

NURSING STAFF

Superintendent Nursing Officer—

Miss I. Mansbridge, S.R.N., S.C.M., Q.N., H.V. Cert.	Administrative. Also home help organiser.

Deputy Superintendent Nursing Officer —

Miss S. Keeler, S.R.N., S.C.M., Q.N., H.V. Cert.	Administrative. Also home help service.

Assistant Superintendent Nursing Officers—

Miss F. E. Jackson, S.R.N., S.C.M., Q.N., H.V. Cert.	Administrative. Also home help service.
Mrs. A. Steele, S.R.N., S.C.M., Q.N., H.V. Cert.	

Health Visitors—

Miss M. Henderson, S.R.N., S.C.M., H.V. Cert.	Tuberculosis (Chest Centre) 50% Domiciliary visiting 50%
Miss M. E. M. Gibson, S.R.N., S.C.M., H.V. Cert.	
Miss A. Booth, S.R.N., S.C.M., H.V. Cert.	Domiciliary visiting, school health service, maternity & child welfare, tuberculosis visiting, special enquiries.
Mrs. S. Bowe, S.R.N,, S.C.M., H.V. Cert.	
Miss M. C. Burgess, S.R.N., S.C.M., H.V. Cert.	
Miss M. Coates, S.R.N., S.C.M., H.V. Cert. (Resigned 30th December, 1953)	
Miss E. Crosby, S.R.N., S.C.M., H.V. Cert.	
Miss E. M. Garrett, S.R.N., S.C.M., H.V. Cert.	
Miss D. Green, S.R.N., S.C.M., H.V. Cert.	
Miss M. E. Harrison, S.R.N., S.C.M., H.V. Cert.	
Miss M. Hastings, S.R.N., S.C.M., H.V. Cert.	
Miss R. J. V. Hind, S.R.N., S.C.M., H.V. Cert.	
Miss M. Horn, S.R.N., S.C.M., H.V. Cert.	
Miss A. Hodgson, S.R.N., S.C.M., H.V. Cert.	
Miss F. Kendall, S.R.N., S.C.M., H.V Cert.	
Miss A. M. Little, S.R.N., S.C.M., H.V. Cert.	
Miss R. A. Lodge, S.R.N., S.C.M., H.V. Cert.	
Miss E. Mercer, S.R.N., S.C.M., H.V. Cert.	

ORTHOPAEDIC PHYSIOTHERAPISTS

Miss J. M. Morris, C.S.P., M.E.	Administrative, clinical and domiciliary visiting.
Miss B. M. W. Summerson, C.S.P., L.E.T. (Orthopaedic Nursing Certificate)	Clinical and domiciliary visiting.

SPEECH THERAPISTS

Miss D. Chapman, L.C.S.T.
Miss M. E. Rawle, L.C.S.T.

ORTHOPTIST

Miss J. F. Maughan, D.B.O.

MENTAL HEALTH

Consultant Psychiatrists—Part-Time

Seconded from Newcastle Regional Hospital Board

J. Braithwaite, M.B., Ch.B., D.P.M.
J. R. Stuart, M.B., Ch.B., D.P.M.
T. T. Ferguson, L.R.C.P., L.R.C.S., L.R.F.P.S.

Administrative Assistant—

N. Froggatt.

Psychiatric Social Workers—

Miss M. Lamb
(Part-time. Seconded from Newcastle Regional Hospital Board)
Miss J. Simpson, B.A.
) Child Guidance.

Mental Health Workers—

Miss E. Hall
Miss A. G. N. O'Regan

ADMINISTRATIVE OFFICER

W. Butcher

Health Education

During 1953 interest in health education was stimulated by two small exhibitions showing health education methods, to which were invited County officials and members of the Health Committee. One was held in May at the Child Welfare Clinic, Portland Square, Carlisle, and the other in July at Sandhills Lane Clinic, Whitehaven. At the latter prominence was given to the hygiene of food handling. Dr. Faulds co-operated by lending slides showing cultures of bacteria from hands and washing up water, and in the afternoon a talk on the subject was given to the catering and

kitchen personnel from the hospitals in West Cumberland. At both exhibitions some interesting demonstrations were shown by the health visitors.

During the year all the child welfare clinics were supplied with a variety of new posters, leaflets and a flannelgraph. At child welfare clinics talks and demonstrations have been given by the health visitors on subjects such as the prevention of accidents in the home, the hygiene of food handling, nutrition, care of the feet, the prevention and care of infectious diseases —especially tuberculosis, and other subjects. At one or two ante-natal clinics talks were given to expectant mothers. Where the nurses have district rooms, posters and leaflets have been supplied for display and some of the nurses are arranging to use these rooms for talks and to hold discussions amongst small groups of mothers.

The administrative staff and a number of health visitors and district nurses have been included on the panel of lecturers of the Cumberland Federation of Women's Institutes, and many requests for lectures have been received for 1954. In addition, it might be mentioned that a number of our staff give lectures to branches of the Red Cross and St. John Ambulance Brigade, on home nursing, first-aid and welfare. This gives an opportunity for health propaganda at the same time.

The Health Committee have approved the purchase in the financial year 1954-55 of a film strip projector, screen, and an adequate selection of film strips. These will be used by lecturers to illustrate their talks and demonstrations, and I would hope that some selected film strips on appropriate subjects will be available for demonstration, if desired, in some of the larger schools in the county.

It is intended to hold two health exhibitions for the general public in Workington and Whitehaven during the summer of 1954, on a larger scale than previous exhibitions.

NATIONAL HEALTH SERVICE ACT, 1946

Part III

Part V

SECTION 21

Health Centres

No change has taken place in this matter during the year.

Clinics

A good deal of useful progress has been made here. The long awaited new clinic at Millom will be open for use before this report is in your hands.

The Ministry have approved the plans for a new clinic at Penrith and building will also have started before this report is issued. It is interesting to recall that the Penrith clinic now about to be replaced was the first clinic and tuberculosis dispensary to be opened in the county over 40 years ago, so it owes us nothing.

Approval has also been asked from the Ministry for the erection of an ancillary clinic to be erected in the new building area in the Valley at Whitehaven. At the time of writing approval has not been obtained for the erection of this clinic and the matter is still under discussion.

The largest project before us is, however, the building on the Flatt Walks site at Whitehaven, if this becomes available through agreement with the Whitehaven Town Council, of a new suite of clinic buildings and of a small area health office, to replace those at present in use. Our present clinic premises in Whitehaven at Sandhills Lane and 10, Scotch Street are quite out of date. They are cramped and very inconveniently constructed for clinic use, and, in the case of Sandhills Lane, involve the use of three storeys. The premises at 10, Scotch Street, although much smaller, are even worse. When it is remembered that the total attendances at Sandhills Lane Clinic alone exceed 20,000 a year, the justification for erecting modern clinic buildings is apparent.

All the above means that we will have, when (and if) this programme is completed, gone a considerable way towards the accomplishment of the 5-year plan which was decided upon before the outbreak of war. The worst of our problems will have been solved, but the replacement of perhaps two of our other older clinics will have to come up for consideration in due course.

THE NURSING SERVICES

Section 22—Care of Mothers and Young Children.
Section 23—Midwives Service.
Section 24—Health Visiting.
Section 25—Home Nursing.

The broad principles governing the establishment of our nursing services consequent upon:—

(a) the passing of the Midwives Act, 1936, and

(b) the coming into operation in 1948 of the National Health Service Act, 1946.

have been very fully analysed in previous annual reports, and no useful purpose would be served in going now into any great detail. Recasting, however, one must recall that the ultimate target, so far as district nursing is concerned, has been to build up an establishment of state registered nurses if possible with Queen's district training, and that each district nurse, with the exception of one or two urban areas, should be provided with a car, and that all district nurses should be on the telephone.

With regard to the matter of qualifications, the position is that we now employ 49 Queen's or state registered nurses, and 28 state enrolled assistant nurses, all, with the exception of nine, being state certified midwives. This means that we have made quite a step forward towards our target in respect of qualifications. Of the 49 Queens or state registered nurses doing district work in the county, 6 hold the Health Visitors Certificate, 3 having completed their training under the Council's scholarship arrangements during the year. Of the remainder of the district nurses 41, all in rural areas, undertake health visiting under a dispensation granted by the Ministry. So far as I can see this dispensation is not likely to be terminated within any foreseeable time, because the training for the Health Visitor's Certificate takes nine months, and in nearly every case is accompanied by an application for one of the Council's scholarships (which amount to £250) to cover the training period.

The Council at present grant three of these scholarships annually. It is therefore clear that, both from the staffing and the financial points of view, it is going to be a very long time before all of our district nurses hold the Health Visitor's Certificate.

The above refers to district nurses and district nurse midwives. The position with regard to whole-time midwives and whole-time health visitors is dealt with under the appropriate sections.

The housing position has improved somewhat during the year. The County Council completed 4 houses during the year at Penrith, Burgh-by-Sands, Irthington and Hesket. District councils built for us 3 houses during the year at Maryport, Wigton, and Lorton. At the time of writing this report 4 houses are under construction by the County Council at Parton, Bothel, Frizington, and Caldbeck, and 4 by the district councils at Braithwaite, Fletchertown, Cleator Moor, and Abbeytown. The majority of the houses indicated above as built by district councils, were in fact built by the North-Eastern Housing Association acting as agents for the district councils concerned. By the end of 1953 the housing position as affecting district nurse midwives was as follows:—

Houses rented by the County Council	22
Houses bought by the County Council, previously owned by district nursing associations ...	9
Houses built by the County Council	5
	36

Of the remaining district nurses, only two at the moment are living in rooms, and of course it has to be remembered that there are some vacancies where the nurses, when we find them, may be accommodated in rooms. The remainder of the nurses are living in houses owned or rented by themselves.

We still have a considerable programme of rehousing of district nurses. This may at first sight seem strange, but the reason is twofold. The first is that when district nurses presently living in property owned or rented by themselves, retire or leave the district, we have no house to offer to the incoming nurse. The second reason is that a number of the nurses at present are living in houses from which the district nursing service is not conveniently carried on. Some nurses in fact are living in houses without attached garages or garages conveniently near, and without district rooms. There is therefore ample justification for the modest programme still be carried out.

In the matter of transport, the County Council now

own 68 nurses cars for all types of nurses, and 24 nurses, health visitors, whole-time midwives, and district nurses, own their own cars. Only 3 district nurses are now without motor transport. All the wholetime midwives are provided with motor transport except one. Facilities for engaging taxis for the transport of gas and air apparatus, or in emergency, are of course still available to all midwives or district nurse midwives not yet provided with cars.

The number of district nurses not yet on the telephone has been reduced to 2 and it is anticipated that these 2 will be provided with telephones during the coming year.

At the time of writing there are 5 nursing districts which are vacant. This is worse than twelve months ago when there were only 2 vacant districts, but we hope by the end of the year to have filled all the vacancies from nurses at present undergoing Queens District Training, and from some outside appointments. At the same time it has to be remembered that new vacancies are continually occurring and the filling of these vacancies is still difficult, and we have to depend almost entirely on filling vacancies from our own trainees. We know, of course, that if a nursing vacancy is advertised in many other parts of the country there are a considerable number of applicants and the authority is therefore in a position to make a choice. Here in the north the position is different, and at times we advertise vacancies without receiving any applications. This emphasises the importance of proceeding with our housing programme, because being in the position to offer an attractive house is often a determining factor.

The Superintendent Nursing Officer, or her assistants, paid 200 routine visits of inspection, and 546 special visits of one kind or another, during the year.

Finally, the following points are of interest. Our co-operation in the National Survey of the Health and Development of children continued during the year. By arrangements with Bolton Technical College Health Visitors Course, we have during the year given experience in work in a rural area to 3 student health visitors. Student nurses from the Cumberland Infirmary and Whitehaven and Workington hospitals have been out on the district with some of our district nurses. This

is in keeping with the desire of the General Nursing Council in the reconstruction of their syllabus of training for the state registered nurse's certificate, that nurses in training should be made aware of the social aspects of hospital and nursing work generally. The new syllabus provides that 4 lectures will be given by certain specified persons to each group of nurses in training during the course of that training, and that all nurses in training will have an opportunity to see something of district work and of the social problems of patients outside the hospitals and of the facilities offered by local health authorities in the solution of these problems, such as the provision of home helps, the ambulance and sitting case car service, the mental health service, and other matters.

In September, 1952, Workington Infirmary instituted with the approval of the Central Midwives Board, courses in training for Part II of the Midwifery Training Regulations. Since that time we have worked in close co-operation with Workington Infirmary in this matter, and 8 pupils midwives per year receive training under our district midwives in Whitehaven, the pupils being resident for periods of 3 months each in the home of one of the district midwives. I should like here to pay a tribute to the work which the district midwives in Whitehaven have done in this connection, and I am glad to be able to say that all the pupil midwives concerned were successful in passing their examination for the state certificate.

Miss Mansbridge, Superintendent Nursing Officer, had the honour of being presented with the long service badge of the Queen's Institute of District Nursing by Her Majesty the Queen Mother, at St. James' Palace, in December.

Nurse Benn's work as district midwife at Cleator Moor for 20 years, during which time she has given ungrudging service to the community, often under conditions of extreme strain, was recognised by the award to her of the Coronation Medal.

SECTION 22

Care of Mothers and Young Children

The statistics for the year are as under, and are set out in accordance with a new table devised by the Ministry:—

CHILD WELFARE CENTRES

No. of centres provided at end of year.	No. of Child Welfare sessions now held per month.	No. of children who first attended a centre of this Local Health Authority during the year, and who at their first attendance were under 1 year of age.	Number of children who attended during the year and who were born in			Total Number of children who attended during the year.	Number of attendances during the year made by children who at the date of attendance were:			Total Attendances during the year.
			1953	1952	1951-48		Under 1 year	1 but under 2	2 but under 5	
15	62	1643	1043	1198	1482	3723	9889	2735	2479	15103

WEIGHT AT BIRTH.	Premature Live Births																		Premature Still-Births		
	* Born in Hospital.			Born at home and nursed entirely at home.			Born at home and transferred to hospital on or before 28th day.			Born in nursing home and nursed entirely there.			Born in nursing home and transferred to hospital on or before 28th day.			Born in hospital.	Born at home.	Born in nursing home.
	Total	Died within 24 hours of birth.	Survived 28 days.	Total	Died within 24 hours of birth.	Survived 28 days.	Total	Died within 24 hours of birth.	Survived 28 days.	Total	Died within 24 hours of birth.	Survived 28 days.	Total	Died within 24 hours of birth.	Survived 28 days.			
(a) 3 lb. 4 oz. or less (1,500 gms. or less)	17	2	10	1	1	—	6	2	3	—	—	—	—	—	—	20	4	—
(b) Over 3 lb. 4 oz. up to and including 4 lb. 6 oz. (1,500—2,000 gms.)	27	4	19	4	1	2	9	2	5	—	—	—	—	—	—	5	1	1
(c) Over 4 lb. 6 oz. up to and including 4 lb. 15 oz. (2,000—2,250 gms.)	39	—	38	3	—	3	7	—	7	1	—	—	1	1	—	4	2	—
(d) Over 4 lb. 15 oz. up to and including 5 lb. 8 oz. (2,250—2,500 gms.)	67	1	64	26	1	25	3	—	3	2	—	2	—	—	—	7	1	—
TOTALS	150	7	131	34	3	30	25	4	18	3	—	2	1	1	—	36	8	1

* The group under this heading includes cases born in one hospital and transferred to another.

The above figures do not differ materially from those of the previous year. The total attendances show some decrease.

With regard to illegitimate children, 80 cases were specially investigated and in only 2 was there any question that the conditions prevailing were unsatisfactory. These cases were referred to the Children's Officer for further investigation.

The agency arrangements for unmarried mothers continued as before. Five girls were admitted to Coledale Hall, Carlisle, prior to their confinements. This is a very substantial reduction from the previous year when 19 such cases were admitted. Reference will be made under Section 23 to the actual cases of unmarried mothers admitted to St. Monica's Home and Brettargh Holt Home for their confinements.

Premature Infants.

A premature infant is a child whose weight at birth is 5½ lbs. or less. Actually the smallest child born during the year weighed 1lb. 13ozs. This was one of a pair of premature twins, the weight of the second being 1lb. 15ozs., and it is gratifying to be able to say that both these children survived. They were born in Workington Infirmary.

The statistics with regard to prematurity are shown in the following table. This table differs from the corresponding table for the previous year on the directions of the Ministry and calls for some comment. It will be seen that 213 children were born prematurely—150 in hospital, 59 at home, of whom 25 were transferred to hospital. The remainder were born in nursing homes. Of the 213 premature births, 32 infants died within 28 days. This figure cannot be deduced from the table in its new form. The inclusion of premature still-births is a new feature in this table and it will be noted that there were 45 of these.

Units for the reception of premature infants have been established at the City Maternity Hospital, Carlisle, and at Workington Infirmary. In the past I have not been altogether satisfied with the arrangements for premature infants in hospital, either as regards staffing or equipment, nor have I been satisfied from our own angle with regard to the measures for ensuring the well-being of premature infants transferred long distances to hospital. If a premature child's condition is such that it merits removal to hospital, it is obvious that it is, to put it quite bluntly, not in a good way, and quite obviously something had to be done about that. During the year I was given authority to obtain the necessary equipment, which consists of 2 Sorrento premature baby cots and 2 Queen Charlotte infant oxygen tents. These have now been received and arrangements have been made that, on a call being received from a practitioner or a midwife asking for the removal of a premature infant from home to hospital, one of our ambulances in East or West Cumberland, as the case may be, will proceed to the appropriate premature unit and collect this equipment with a nurse from the unit and will then proceed to the home of the infant and undertake the removal to hospital. Our ambulances of course are all heated, and in addition the premature baby cots have pockets in their linings for 4 hot water bottles. These will be filled before the ambulance starts on the journey and all midwives have been instructed to have hot water available at the home of the infant to refill these bottles for the return journey. These arrangements, which have been agreed with the hospitals, have been notified to all practitioners and midwives in the county, and seem to be as complete as we can make them.

The need for every care in this matter of premature babies is obvious when we remember that 122 premature infants have died in the first month of life during the last three years.

With regard to the hospitals, the sisters in charge of the premature units have now been specially trained in this subject and the equipment has been brought up to a satisfactory standard. The equipment at Workington Infirmary is particularly good.

As noted in previous reports, so far as our own domiciliary service for premature infants is concerned,

and additional to the ambulance premature equipment, we maintain 12 premature baby cots for use at home in cases where the premature infants do not require removal to hospital.

Before leaving this section on prematurity, I would like to mention that some months ago 2 cases of a rare disease known as retrolental fibroplasia came to our notice. This condition is one arising in premature infants and concerns a condition of the eyes which normally, and I think invariably, leads to total blindness. It is now generally accepted that the cause of this condition is linked up with the administration of oxygen to premature infants. It appears to be the case that if oxygen is administered for long periods in too high a concentration, or if the transfer from the oxygen tent to the open air of the premature unit is made too abruptly, there is a risk of this condition supervening. Apparently the advisable concentration of oxygen is not exceeding 40% and apparently the transfer from the oxygen tent should be done gradually starting say with half an hour or one hour on the first occasion and gradually increasing. It is, of course, almost a paradox that oxygen which plays so large a part in saving the life of the premature infant, may exceptionally bring about disaster in the shape of blindness. These cases are so rare that the consultant ophthalmologists in the county have told me that since they took up their duties here they have not seen a case, but curiously quite recently this condition developed in a premature child born in the county, and another child with the same condition was transferred to the same town in Cumberland from the South of England.

The following table shows the extent to which practitioners were concerned in the ante-natal and post-natal examination of expectant mothers in cases booked as midwives cases.

Examinations at practitioners' surgeries ...	690
Examinations at Patients' homes	168
Examinations by practitioners at clinics ...	156
Re-examinations	1,116
Total	2,130
Findings at examinations—Normal	817
Abnormal	197

Recommended for hospital on account of home conditions	113
Recommended for hospital on account of patient's condition	29
Recommended to be seen by specialist ...	34
Post Natal examinations	247

The above table includes ante-natal and post-natal examinations at the County Council clinics at Maryport, Workington, Egremont and Cleator Moor where the local practitioners use the facilities which we have been very glad to place at their disposal.

The table deals only with domiciliary examinations. In addition, of course, a very large amount of ante-natal and post-natal work is undertaken at the hospital clinics by specialists attached to these clinics. In practice we send quite a substantial number of cases, with the approval of the practitioners, for ante-natal examination and advice to the consultants attached to the hospitals concerned.

The following statistics supplied by the Hospital Management Committees are of interest:—

Hospital ante-natal cases		Patients admitted for ante-natal treatment	Patients delivered in hospital	Children born in hospital	No. of maternal deaths in hospital	No of infants born in hospital died before discharge
Patients	Attendances					
			EAST CUMBERLAND			
874	2,944	108	890	899	3*	19
			WEST CUMBERLAND			
1,184	7,700	146	1,045	1,065	2	15
2,058	10,644	254	1,935	1,964	5	34

* Includes one case transferred after Caesarean section from Workington Infirmary to Garlands Mental Hospital.

The above table, which incidentally includes 19 confinements in the maternity unit at Meadow View House, but excludes confinements in nursing homes, whether in Carlisle or in the administrative county, shows that 1,935 deliveries took place in hospital, more or less equally divided between East and West Cumberland. This figure is slightly higher than for the previous year.

With regard to children's homes and nurseries, our only day nursery at Flatt Walks, Whitehaven, was closed during the year for conversion into an occupation centre for mental defectives. With regard to residential children's homes and nurseries, the complement of available beds reached a new high total of 168 during the year by the opening of Geltsdale children's home at Wetheral. This home is primarily for boys of 8 years and upwards. Our list of children's homes and nurseries is therefore now 6. Sandath Nursery at Penrith, is perhaps, the only strictly nursery accommodation for very young children available for residential cases in the county.

SECTION 23

Midwives Service

During the year 118 midwives notified their intention to practise. These notifications include 10 whole-time district midwives, 76 district nurse midwives, 30 midwives working in the maternity department of hospitals in the administrative county and 2 midwives acting independently.

The number of domiciliary confinements undertaken during the year was 1,541. The Ministry ask for the figures to be returned in a somewhat different form from previous years, as follows:—

Cases in which a doctor was booked and was present at the confinement	363
Cases in which a doctor was booked but was not present at the confinement	454
Cases in which a doctor was not booked ...	724
	1,541

As a final point, the following short table may be interesting:—

Domiciliary Confinements

	Cases booked by doctors.	Cases not booked by doctors.	Total.	
East Cumberland ...	301	101 ...	402	
West Cumberland ...	516	623 ...	1,139	
				1,541

This table shows that the fall in domiciliary midwifery continues. The reason may or may partly be a fall in the total birth rate, the figures for which at the moment of writing are not yet available. There is no doubt that the fall in the figures for domiciliary confinements is regretted by the midwives, some of whom may only have one or two confinements to attend during the twelve months. On the other hand, the demand for confinement in hospital means that the maternity departments are working under great pressure, and it also means that many patients have to be discharged before the fourteenth day which is regrettable. The actual number of cases discharged from hospital before the fourteenth day during the year was 720.

Our district nurse midwives and midwives continue, when requested, to provide information for the obstetricians on home conditions and other factors which have a bearing on allotting priority for maternity beds in hospital to women who apply for or who are recommended for hospital confinement on social grounds.

The following short table shows the position in respect of ante-natal and post-natal visits by midwives covering midwifery and maternity.

Home visits	12,415
Attendances at nurses' clinics	5,953
Total	18,368

During the year midwives sent for medical help in domiciliary cases on 461 occasions.

The Rh. Factor and Wassermann Testing

I referred to this matter at length in last year's report. I mentioned that at the request of the Senior Consultant Obstetrician and of the Consultant Venereologist. letters had been issued to all practitioners in the county. asking for their co-operation. Progress in this matter was the subject of investigation towards the end of the year by the above consultants in conjunction with the Senior Consultant Pathologist and myself. Following upon this a further letter was issued to all practitioners as follows: —

11 Portland Square.
Carlisle,
December, 1953.

Dear Doctor,

Blood Testing of Expectant Mothers for (a) Rhesus Factor, (b) Blood Grouping, and (c) Wassermann

You will shortly be receiving from the Director of the Regional Blood Transfusion Centre in Newcastle a card relative to the above. **The card is designed primarily to draw attention to the importance of the Rhesus Factor with special reference to haemolytic disease of the new-born in cases where the expectant mother is Rh. negative.**

Every blood specimen from an expectant mother taken in order to ascertain the Rhesus position is also automatically examined at the Cumberland Infirmary Laboratory for the A.B.O. blood group and for the Wassermann reaction. The examination of these ante-natal blood specimens gives invaluable information in respect of the risk or otherwise of haemolytic disease occurring in the infant. Knowledge of the blood group saves precious time should a transfusion be required. Also, the discovery of a positive Wassermann reaction makes it possible to bring the mother and child under treatment, and, if necessary, other children in the family.

Circular letters on this subject were sent in 1951, signed by Dr. Bell, Mr. Nicholson and the County Medical Officer to all practitioners practising midwifery in the administrative county.

The County Council as from that date have made available to practitioners adequate supplies of Bayer's Venules for use in connection either with midwives or doctors' cases and have agreed to pay the practitioner a fee in connection with samples taken in midwives' cases.

We know that ante-natal cases attending hospital ante-natal clinics are investigated automatically, but unhappily the position in respect of domiciliary confinements is that at present in the administrative county out of something approaching 1,700 domiciliary confinements annually **in less than one in three confinements are ante-natal blood specimens taken.** (Between 1st April and 30th September, 1953, one practice sent in 40 specimens, the majority less than 10, many practices sent us only one specimen and 45 practices sent in none at all).

We are writing to ask all our colleagues in general practice in the county to help us to attain the target of one blood specimen from every pregnancy and **in the case of Rhesus negative women a second specimen without fail at the 32nd week.**

Yours sincerely,

H. J. BELL
J. STEVEN FAULDS
KENNETH FRASER
E. L. NICHOLSON

The great difficulty in this matter does not really lie in the taking of the blood specimens, with which I am sure the practitioners in the area will give us every co-operation, nor does it lie in the laboratory investigation. The real difficulty lies in ensuring that when a woman has been found to fall in the Rh. negative group she is made aware of the extreme importance of this finding, both to herself, in the case of a blood transfusion becoming necessary, and to the child in the event of future pregnancies. It was therefore agreed by the four signatories to the letter, after consultation with the other consultant obstetricians in the area, and with a number of representative practitioners, that cards should be printed which would be handed to the women either by the hospitals, if they were hospital cases, or by the practitioners if they were domiciliary cases. Two types of cards have been printed, one for cases where the woman's blood is Rh. positive, and the other for cases when the woman's blood is Rh. negative, with or without antibodies. The idea is that it should be impressed upon women in this group that it is of the utmost importance that should they be admitted to hospital for any serious condition which might involve a blood transfusion, or should they again become pregnant, this card must be produced to their doctor or to the hospital doctor as the case may be, and must be taken with them should they leave the county to proceed to another area, and be shown to whatever doctor is appropriate in the new area should the occasion arise.

It is, I think worth while to reproduce below the instructions we will issue to women who are of child bearing age, and whose blood is Rhesus negative, by means of cards. Our suggestion is that on the reverse of the national blood transfusion cards the special wording indicated below *above the line* (which will be in red) should be used for issue to the women concerned in this county. Our suggestions have, I am glad to say, been approved by the national blood transfusion service.

Important to Women of Child Bearing Age

"In the event of your again becoming pregnant the information on this card in the hands of your doctor, or of a hospital doctor, may mean the saving of your life, or that of your child.

This card should be kept with great care, and not only yourself, but other members of your household should know where to get it at once in an emergency.

To the Holder of this Card

There are many different groups of blood; your blood is of a special group not often met with. In some circumstances this might be important, so you should keep this care carefully, and if you are ever admitted to hospital you should show it to the doctor.

This card is an important document; the particulars on it relate only to you, and you should never let it be presented or used by any other person."

The importance of this matter may be demonstrated from a leading article in the British Medical Journal which drew attention to the fact that during 1952, 435 infants in England and Wales died from haemolytic disease of the new-born, which is the condition resulting from what may be described as a conflict between the blood of the male and female parent in these cases. It should be clear too, that in addition to actual deaths, ill-health is liable to occur in many cases which do not actually die.

These specimens of blood from expectant mothers are also of course tested for the Wassermann reaction, and although this is found positive in only a very limited number of cases, the discovery of a positive reaction is of the greatest importance both to the mother and the child, and indeed to all members of the household concerned.

Gas and Air Analgesia

By the end of 1953 all our midwives except one or two had been trained in gas and air analgesia, and it is practically certain that by the end of 1954 all our midwives will be so trained. This means that this service is available to all women who desire to avail themselves of it at their confinements.

The number of occasions on which gas and air analgesia was employed in domiciliary midwifery or maternity by midwives during the year was 886. Of this number a doctor was present at 182 confinements and was not present at the remainder. The total figure shows a small decrease from the previous year, partly no doubt due to fewer births, and possibly by the use of other analgesics by practitioners. The use of pethidine as an analgesic by midwives is extending considerably, some 20 midwives having been authorised to use this sedative, which of course may be used by itself or in conjunction with gas and air analgesia.

The interpretation of these figures, which are necessarily complicated, *seems* to be that something like one-third of the domiciliary confinements do not have gas and air or any other analgesia. This seems to be explained by the fact that quite a number of women are offered gas and air and refuse it, by the fact that in quite a number of cases labour has been so quick that the child is born before the arrival of the midwife or the doctor, and for other reasons.

MATERNAL MORTALITY

Five maternal deaths occurred during the year, giving a maternal mortality rate of 1.34. The figures for maternal deaths in the last 5 years have been as under:—

1949—7	deaths	equal	to	a	rate	of	1.74	per	1,000	births.
1950—5	,,	,,	,,	,,	,,	,,	1.28	,,	,,	,,
1951—1	,,	,,	,,	,,	,,	,,	0.26	,,	,,	,,
1952—3	,,	,,	,,	,,	,,	,,	0.79	,,	,,	,,
1953—5	,,	,,	,,	,,	,,	,,	1.34	,,	,,	,,

To the figures for hospital admissions for confinement which have been given earlier in this section should be added the following:—

St. Monica's Maternity Home, Kendal	11
Brettargh Holt Maternity Home, Kendal ...	2

Fifty-four cases of puerperal pyrexia were notified during the year. No cases of ophthalmia neonatorum or pemphigus neonatorum occurred during the year.

SECTION 24

Health Visiting

Our staff of whole-time health visitors at the end of the year amounted to 19 including 1 vacancy. As men-

tioned earlier, much of the health visiting is done by the district nurses, of whom 46 are concerned, and of these, as noted previously, 5 hold the health visitors certificate, the balance being continued under temporary year to year approval by the Ministry.

During the year the value of our scholarships for health visitors in training was raised from £225 to £250 to bring these scholarships into line with the increased cost of living.

The work undertaken by our health visitors and district nurses during the year was as undernoted:—

Visits to children under 1 year	34,007
Visits to children aged 1-5 years	38,339
	72,346

These figures show a slight reduction from those for the previous year. This is partly due to the fact that our health visitors have been devoting an increasing amount of time to problem families in different parts of the county. The number of problem families kept under supervision reached the surprising figure of 167. This work has been carried out in close co-operation with the Children's Officer. Whether the figure will rise or fall in future is anybody's guess. The distribution of the families visited was as under:—

Rural districts		Urban Districts	
Alston	3	Cockermouth	10
Border	23	Maryport	35
Cockermouth	4	Penrith	12
Ennerdale	24	Whitehaven Borough ..	14
Keswick	2	Workington Borough ..	21
Millom	3		—
Wigton	16		92
	75		

An increasing amount of time is also being devoted, particularly by the district nurses, to looking after the aged in their own homes.

Certain matters affecting health visitors and the relationships between health visitors and general practitioners have been dealt with in the introductory letter to this report.

SECTION 25

Home Nursing

The statistics relative to home nursing in respect of 1953 set out in accordance with instructions received from the Ministry are as follows:—

	No. of cases	nursed.
Medical	4,843	
Surgical	3,130	
Tuberculosis	403	
Infectious diseases	57	
Maternal complications	142	
Others	32	
	8,607	
Number of nursing visits paid ...	136,090	
Number of casual visits paid	4,943	
		141,033

I do not think that I can make any useful comment on this branch of our nursing services. The value of the work is well-known and appreciated. We have a very good staff of district nurses, and, as pointed out earlier, the standard of qualifications we are now looking for is steadily rising. The volume of the work undertaken is manifest from the above figures. Co-operation with the general practitioners is excellent. It is a most valuable service being well carried out, and that is all that there is to say about it.

SECTION 26

Immunisation and Vaccination

(a) Immunisation.

The number of children under school age immunised during the year was 2,493. The number of school children receiving either primary or reinforcing injections was 4,042. In addition 123 pre-school children received reinforcing injections, so that we had a total of 6,658 immunisations carried out during the year. This figure is considerably lower than the figure for 1952, explained no doubt, at least in part, by the fact that during the incidence of poliomyelitis in the county during the summer and autumn months diptheria

immunisation practically ceased in the schools. The figure of 6,658 immunisations includes 1,230 reports received from general practitioners in respect of immunisations carried out privately, the majority of these reports referring to children under school age.

I have pointed out in previous reports that the number of record cards received from general practitioners, when claiming the appropriate fee from the County Council for reporting the immunisation, cannot be taken as indicating correctly the considerable volume of immunisations carried out by general practitioners privately. Quite a number of practices do not send in any of these reports, and other practices from which formerly these reports were received in considerable numbers, now hardly forward any. This means of course, that our records are necessarily incomplete, and also means that the practitioners do not receive the fees for these reports to which they are entitled. I regret this because we do in fact in this matter, attempt to keep the clerical work called for from practitioners in this respect, down to an absolute minimum. We arrange for the detailed account forms to be completed in this department and forwarded to the practitioner, requiring only his signature in order that the fees to which he is entitled may be paid. Immunisation done privately by practitioners in the main concerns children under school age. The majority of reinforcing or " booster " doses are given to children in school by members of our medical staff.

The following table shows the trend in respect of immunisation both as regards primary and reinforcing injections for the past 10 years.

1953	...	6,658
1952	...	8,915
1951	...	6,489
1950	...	7,161
1949	...	10,409
1948	...	7,235
1947	...	5,491
1946	...	7,318
1945	...	3,747
1944	...	3,936

In November the Ministry issued a circular (L.H.A.L. 3/53) indicating that the view is now held that a child who has not received a reinforcing injection within the last 5 years cannot be regarded as fully

protected against diphtheria. The form of annual return required by the Ministry for 1953 accordingly asked us to show the number of children who, although having completed a course of immunisation on the lines operative up till that date, have not been reinforced during the past 5 years. In completing this return we find that some 8,143 children of school age who have been immunised in the past, cannot now be regarded as possessed of full immunity. Steps have at once been taken to deal with this during the current year by asking all parents to agree to a second reinforcing or "booster" dose in respect of their children at the age of 10/11 years. This new approach has of course considerably affected our percentage figures of children who may be regarded as fully immunised. At the end of 1953 these figures are:—

Under 5 years	51%
5-15 years	76%

These figures, so far as under 5 is concerned, are almost identical with the previous year, but in the 5-15 year group the percentage of children regarded as completely protected has fallen from 95% to 76%.

The head teachers in the county schools have co-operated extremely well in this matter of the reinforcing injections due on the child's entry to school. They deserve our thanks for their co-operation, and I have no doubt that they will help us also in this important matter of the second reinforcing injection in the 10/11 year old group. The head teachers have allowed us to bring pre-school children to immunisation sessions in school, which help in rural areas has been of the greatest value.

(b) Vaccination.

Vaccination is not undertaken by the medical staff of the authority, but is carried out by general practitioners. During 1953 we received 1,244 record cards from practitioners in respect of successful primary vaccinations, and some 310 cards in respect of re-vaccinations. Of the 1,244 primary vaccinations, 1,042 referred to infants under 12 months of age. Using the Registrar General's estimated population figures, this would roughly give a figure for successful primary infant vaccinations of 29%, which is some improvement on the 1952 figure, and I believe is higher than the national figure.

SECTION 27

Ambulance and Sitting Case Car Service

No lengthy reference to this service is necessary. The details of the organisation have been very fully set out in previous reports. The statistical table which follows gives a bird's eye view of the position. The table shows that there has been an increase in the total number of journeys of 1,259, of patients carried of 15,827, and in total mileage of 28,737. The ambulances proper show an increase of 220 journeys, of 2,811 patients carried, and a *decrease* in mileage of 12,619 miles compared with the previous year.

The sitting case car service and hospital car service combined show an increase of 1,037 journeys, of 13,016 patients carried, and a mileage increase of 41,356 miles. This increased total mileage is largely due to the increased conveyance of patients in connection with the development of the chest service in West Cumberland. Compared with the previous year there has also been an increase in the number of patients requiring transport attending rehabilitation departments at the Cumberland Infirmary, Workington, Whitehaven, and one or two of the cottage hospitals.

During the past year many patients have been sent for specialist investigation or treatment to hospitals in Edinburgh, and there has also been a considerable increase in the number of patients sent to the Royal Victoria Infirmary, Newcastle, and to the Newcastle General Hospital. A considerable number of cases of amputations, etc., are sent to the Ministry of Health Limb Fitting Centre at Newcastle for the fitting or checking of artificial limbs and for walking exercises. These amputation cases not uncommonly attend for twelve months at monthly intervals. It is a simple matter of arithmetic to point out that one such case travelling from West Cumberland to Newcastle might involve journeys totalling approximately 2,500 miles in the year.

Three new ambulances were purchased during the year, two of which were dual purpose vehicles for carrying stretcher cases or up to 9 sitting cases each.

One worn out ambulance was disposed of. The total number of ambulances owned by the County Council at the moment is 24, out of which 16 are in regular use, 5 in reserve, and 3 earmarked for civil defence purposes. In addition 4 ambulances privately owned are employed under contract. It will be necessary during the next financial year to purchase one new ambulance and one new light dual purpose vehicle. These dual purpose vehicles have more than justified their existence and without them the total mileage would have shown a much greater increase.

The call-out bureaux at the Cumberland Infirmary and Whitehaven Hospital continue to play an extremely important part in the service. There is no doubt in my mind that the establishment of these call-out bureaux, besides being of considerable convenience to the hospitals, have relieved us of at least some of the difficulties which have been experienced in other areas.

	AMBULANCES.			SITTING CASE CARS.			HOSPITAL CAR SERVICE.			SUMMARY OF ALL SERVICES.		
	Total No. of Journeys.	Total No. of Pats. Carried.	Total Mileage.	Total No. of Journeys.	Total No. of Pats. Carried.	Total Mileage.	Total No. of Journeys.	Total No. of Pats. Carried.	Total Mileage.	Total No. of Journeys.	Total No. of Pats. Carried.	Total Mileage.
Totals for year ended 31st March, 1953 ...	8,293	22,086	263,123	13,817	34,172	335,093	1,857	4,794	79,866	23,967	61,052	678,082
March, 1954 ... ended 31st Totals for year	3,515	24,897	250,504	15,031	47,401	391,080	1,680	4,581	65,235	25,226	76,879	706,819
Increase for year ended 31st March, 1954, compared with 1952/53	222	2,811	——	1,214	13,229	55,987	——	——	——	1,259	15,827	28,737
Decrease for year ended 31st March, 1954, compared with 1952/53	——	——	12,619	——	——	——	177	213	14,631	——	——	——

(Excluding journeys undertaken by other local Health Authorities).

Financial Position

I am indebted to the County Treasurer for the statement of costs which follows.

AMBULANCE SERVICE, 1953/54.

Including journeys undertaken by other Local Health Authorities

(a) **Mileage and number of patients carried, viz.:—**

	1953/4	1952/3
Ambulances:		
Mileage	253,631	266,656—i.e. a decrease of 13,025 miles.
No of patients carried	24,930	22,119—i.e. an increase of 2,811 patients.
Sitting Case Cars:		
Mileage	460,965	422,068—i.e. an increase of 38,897 miles.
No. of patients carried	52,031	39,014—i.e. an increase of 13,017 patients.
Total:		
Mileage	714,596	688,724—i.e. an increase of 25,872 miles.
No. of patients carried	76,961	61,133—i.e. an increase of 15,828 patients.

b) **Cost:** Including administration and depreciation and interest on vehicles—subject to recoveries from other County and County Borough Councils and subject to Ministry grant under the National Health Service Acts:—

	1953/4 Costs.				1952/3 Costs.			
	Amount	Per patient carried.		Per mile.	Per mile.	Per patient carried.		Amount.
	£	s.	d.	s. d.	s. d.	s.	d.	£
Ambulances ...	21,589	17	4	1/8.4	1/7.7	19	10	21,854
Sitting Case Cars ...	24,502	9	5	1/0.8	1/0.5	11	3	21,899
TOTAL	£46,091	12	0	1/3.5	1/3.2	14	3	£43,753

Points from the table are:—

1. **Expenditure**—in total, the amount increased by £2,338, i.e. from £43,753 (1952/3) to £46,091). The increase is in respect of Sitting Case Cars.

COST OF AMBULANCE SERVICE FOR THE YEAR TO 31st MARCH, 1954.

	1953/54.				1952/53.			
	Patients carried.	Mileage.	Cost.		Cost.		Mileage.	Patients carried.
			Amount.	Per mile.	Per mile	Amount.		
	1.	2.	3.	4.	5.	6.	7.	8.
AMBULANCES AND DUAL PURPOSE VEHICLES.			£	s. d.	s. d.	£		
1. Vehicles owned by County Council and run on their behalf by agents:—								
a. Running expenses (excluding depreciation) ...			11,743 ...	1/3.6	1/3.3 ...	11,688		
b. Depreciation and interest on vehicles based on life of 10 years	15,407	180,954	3,003 ...	4.0	3.1 ...	2,366	183,136	14,359
	15,407	180,954	14,746 ...	1/7.6	1/6.4 ...	14,054	183,136	14,359
2. Vehicles owned and run by a garage proprietor ...	9,490	69,550	4,711 ...	1/4.3	1/4.4 ...	5,459	79,987	7,727
3. Vehicles of other County and County Borough Councils	33	3,127	336 ...	2/1.8	1/11.9 ...	352	3,533	33
4. Direct administration expenses:—								
a. Call out bureaux—proportion	—	253,631	219 ...	0.2	0.2 ...	221	266,656	—
b. Telephone filter service, equipment, medical supplies, printing, stationery, etc.	—	253,631	438 ...	0.4	0.5 ...	567	266,656	—
5. Indirect administration expenses—share of cost of central departments	—	253,631	1,139 ...	1.1	1.1 ...	1,201	266,656	—
6. TOTAL—AMBULANCES	24,930	253,631	£21.589 ...	1/8.4	1/7.7 ...	£21,854	266,656	22,119
Cost per patient carried—1953/4 *17/4*, **1952/3** *19/10*								
SITTING CASE CARS.								
7. Vehicles of hire car proprietors	47,401	391,080	19,936 ...	1/0.2	1/0.2 ...	17,006	335,093	34,172
8. Vehicles of Hospital Car Service volunteers (including grant to Red Cross for administration) ...	4,581	65,235	2,076 ...	7.6	7.5 ...	2,501	79,866	4,794
9. Vehicles of other County and County Borough Councils	49	4,650	138 ...	7.1	6.7 ...	200	7,109	48
10. Direct administration expenses:—								
a. Call-out bureaux—proportion	—	460,965	876 ...	0.5	0.5 ...	885	422,068	—
b. Printing, stationery, etc.	—	460,965	184 ...	0.1	0.1 ...	103	422,068	—
11. Indirect administration expenses—share of cost of central departments	—	460,965	1,292 ...	0.7	0.7 ...	1,204	422,068	—
12. TOTAL—SITTING CASE CARS	52,031	460,965	£24,502 ...	1/0.8	1/0.5 ...	£21,899	422,068	39,014
Cost per patient carried—1953/4 *9/5*; **1952/3** *11/3*.								
13. TOTAL FOR AMBULANCES and SITTING CASE CARS—the cost being subject to recoveries from other County and County Borough Councils and subject to Ministry grant under the National Health Service Acts	76,961	714,596	£46,091 ...	1/3.5	1/3.2 ...	£43,753	688,724	61,133
Cost per patient carried—1953/4 *12/-*; **1952/3** *14/3*								

		Ambulances.	Sitting Case Cars.	Whole Service.
2. **Cost per mile.**				
1953/4 compared with 1952/3.	(	Increase of 0.7d. to 1/8.4d.	Increase of 0.3d. to 1/0.8d.	Increase. of 0.3d. to 1/3.5d.
3. **Cost per patient carried.**				
1953/4 compared with 1952/3.	(	Decrease of 2/6 to 17/4	Decrease of 1/10 to 9/5	Decrease of 2/3 to 12/-

(d) **Number of Vehicles.**

County owned—19 ambulances and 2 dual purpose vehicles.

—3 ambulances held in reserve for Civil Defence.

Privately owned and used by the Council—3 ambulances and 1 dual purpose vehicle. ...

SECTION 28

Prevention of Illness, Care and After-care

As I have said in previous reports, it is never very easy to be precise about our activities under this section, because these naturally merge into the activities of other sections. This is perhaps particularly the case in the sphere of tuberculosis, orthopaedics, and the home help service, but it is almost equally true of the mental health service, the nursing services, and indeed of most sections of our work.

In the matter of tuberculosis, we have always done our utmost to co-operate with the consultant chest physicians, and during 1953 in West Cumberland, co-operation proceeded to the point when half of the time of two of our health visitors was seconded to the chest service proper, the other half of the time of these two health visitors being devoted to domiciliary visiting, chiefly in connection with tuberculosis. These arrangements obviously mean care and after-care par excellence.

The extension of B.C.G. vaccination to an age group of school children, which we propose to start in the early spring of 1955, provides another example of methods for the prevention of illness, and will call for the closest co-operation between the consultant chest physicians and this department. The hope that I expressed 12 months ago that the time might come when our medical staff might take an important share in this work has materialised sooner than I anticipated, because in fact the immunisation of the age group of school children concerned will mainly be undertaken by our own medical staff. The total number of contacts of tuberculous cases vaccinated up to the end of 1953 has been 587, of whom 303 were vaccinated during 1953.

We still issue, at the request of the chest physicians, on loan, open-air shelters to the number of up to 25 as may be required. The demand for this provision is much less than it used to be. At one time we had nearly 50 shelters available for use in this respect. I imagine that the increase in the number of sanatorium beds may have had something to do with it, but I feel that the rise in the number of chronic

still infectious tuberculous cases, due to arrest or modification of the disease by anti-biotics, may well reopen a demand for open-air shelters where space is available in proximity to the patient's home for these shelters to be erected. The value of this position is in fact referred to in a memorandum recently issued by the Ministry, in conjunction with circular 8/54 on measures for the prevention of tuberculosis.

The number of visits paid by our nurses to tuberculous households in 1953, apart from nursing visits, amounted to 6,019, involving 1,335 households. In a number of cases we have provided beds and bedding to enable the infective patient to sleep alone. We have also been able to provide domestic help to 22 households with tuberculous patients.

We have been able, in collaboration with the housing authorities, most of whom give this matter high priority, to do something about helping to rehouse tuberculous families in more suitable accommodation.

Our transport service, both of ambulances and sitting case cars, is of course of fundamental importance to the chest service, and enables patients to be brought to the chest centres for physical or X-ray examination, for refills, and so on. The transport service is also often of great value when households, often including very young children, come up for investigation as contacts, for without the provision of transport in some of these cases, it would be very difficult, if not impossible, for the mothers and young children to attend from a distance.

With regard to other forms of care and after-care, and the prevention of illness, reference has been made elsewhere in this report to the steps we have taken to expand the volume of work undertaken in the blood examination of expectant mothers.

Our loan equipment scheme, both in respect of major and minor equipment is being utilised by the district nurses to an increasing extent. This equipment consists of such things as invalid chairs, air or water beds, premature cots, etc., which we regard as major equipment, and which are stored at depots in Penrith, Carlisle, Maryport, and Whitehaven. A fifth depot will be opened at Millom during the current year when the new clinic premises are in operation. Minor equip-

ment, such as air rings, bed rests, steam kettles, etc., are kept in the district nurses' homes and distributed on loan as required. In the district rooms which are attached to the new district nurses' houses, we provide, as these become available, examination couches, sterilisers and other necessary equipment.

Co-operation with the hospitals in the matter of the after-care of orthopaedic patients discharged from hospital has changed little from last year. I feel sure that we could do much more in this respect if we were given the opportunity.

The provision of occupational therapy still remains an unfulfilled hope. This is a matter for regret. The plain truth, however, is that, although the County Council have authorised the employment of 2 occupational therapists, together with the rather expensive equipment, including special vans, we have been unable, in spite of repeated advertisements, to attract any candidates for these posts.

We continue to help the Consultant Venereologist in the matter of contact tracing, although of course as the incidence of venereal disease is falling, we are not now called upon to help in this matter to anything like the extent which used to be the case.

Our health visitors, including our district nurses acting as health visitors, continue to pay many visits of an advisory nature, which of course is one of their proper functions. The number of such visits paid under the above general heading during 1953 was 710. This figure is additional to, and is not included in, the statistics given under the heading of "The Nursing Services."

Co-operation with the hospitals in the after-care of patients on discharge in such matters as the provision of domestic help and nursing care is increasing, but is not, I feel, anything like what it could be, and I think should be.

We send a certain number of patients for convalescent treatment each year. Actually during 1953 the number so sent was 12. We would be very willing to send more if the cases came to our notice. This provision deals with persons in need of convalescence, who are not eligible for the provision of convalescent

treatment through the hospital service, that is to say, persons who have been ill at home. There must, I feel, be many more than 12 persons in the county in a year who have been ill at home and who could well do with a period of convalescence, which sometimes they are not able to afford, and in connection with which in some cases they may not know the ropes. The patient sent for convalescent treatment by a health authority is under a slight disadvantage in comparison with a hospital patient because convalescent treatment if provided by the hospital service is free, whereas if it is provided by a health authority does involve some payment, usually quite small, by the patient or the patient's relatives on an assessment of financial resources.

SECTION 29

Home Help Service

This service has continued to work smoothly. The arrangement whereby the Superintendent Nursing Officer is also the organiser of the home help service continues to prove most satisfactory. Close co-operation is thereby possible through the other administrative nursing officers with the district nurses, and this close co-operation between the nursing and domestic help services has undoubtedly made for efficiency and economy.

During the year the Superintendent Nursing Officer and her assistants paid 2,001 visits in connection with the service, of which 1,242 were to households requiring the help of the service, or to which home helps had been directed, and 759 were to home helps either before enrolment or in the course of their duties.

The home helps frequently call at the offices at Carlisle and Whitehaven, and one of the assistant nursing officers has one afternoon a week when she sees them at Maryport and Workington clinics. This saves an amount of visiting.

The statistics for the year which follow, show no great variation from the previous year, except in one particular which will be referred to later. The essential problems remain as before, namely:—

(a) An inadequate number of enrolled home helps who are willing to be resident, that is to say home helps whose domestic ties enable them to be mobile to any part of the county. The number, as will be seen from the statistics, of mobile or resident home helps available during the year was two, which of course is completely inadequate to meet the need for this type of home help. There is, of course, nothing anyone can do about it.

(b) The second problem is the unequal distribution of enrolled home helps over the county as a whole. It will be noted, for example, that in the Border Rural District there are 38 enrolled home helps, while in Cockermouth Rural District, with a very similar population, there are only 5. In Aspatria we have 16 enrolled home helps, which is more than the number available in Workington, which has many times the population.

In spite of this unequal distribution, it is fortunate that we have practically never had to turn down an application on the grounds that no home help was available in the district. When such a position has arisen it has usually arisen in rather isolated rural areas. The one part of the county which is a continuing cause for anxiety is Keswick and district.

The number of cases helped has risen substantially from 387 in 1952 to 476 in 1953. This is mainly due to the very large increase of cases coming under the heading of old age and infirmity, which group has risen from 101 in 1952 to 171 in 1953. The very high proportion of long stay cases, that is to say primarily the old age and infirm cases which we have always had in this county is the reason why, from the purely financial aspect, our cost per case works out at among the highest in the country. It is clear of course, that a home help devoting her time mainly to short stay cases, such as confinement cases lasting a fortnight or three weeks, or cases during convalescence after an illness, has a much larger turn over during the year than a home help whose time is primarily devoted to long stay cases of the aged and infirm or other groups whose disability remains. Nevertheless I am quite certain that it is in the long stay type of case that the service proves most valuable and is most welcomed.

We are now in a position to assess the development of this service during the first five years of its operation, and it is interesting to recall that in 1949 we brought the service to 193 households, whereas in 1953 during the fifth year of the operation of the service, we dealt with 476 households.

During the year a new scale for the assessment of charges was adopted by the Council. Details were given in full in last year's report and it is satisfactory to note that the new scale of assessments has not in any way curtailed applications for home help assistance as the statistics show, but on the other hand has narrowed the gap between the gross expenditure on the service and the receipts from assessed contributions, which gap was causing the Council considerable anxiety.

The statistics for the year are as follows:—

1st January, 1953, to 31st December, 1953

Home Helps

No. of persons who have been accepted and enrolled on the register:—		
Whole-time		70
Part-time		124
Mobile (Resident)		2
		196
Less persons resigned from service ...		19
No. on register at 31st December, 1953		177
Districts in which the home helps reside :—		
Alston	4	
Aspatria	16	
Border Rural	38	
Cockermouth	5	
Ennerdale Rural	20	
Keswick and Threlkeld	3	
Maryport, Dearham and Gt. Broughton	22	
Millom and district	5	
Penrith and Penrith Rural	19	
Silloth	9	
Whitehaven, Distington and St. Bees ...	8	
Workington	14	
Wigton and Mealsgate	14	
	—	177

Householders

No. of applications received for Home Helps	517
No. cancelled or not supplied ...	208
No. of new cases helped	270

No. of cases on books 1st January, 1953	206	
Cases pending	39	
Analysis of cases helped :—		
Confinements	83	
Tubercular cases	22	
Old age and infirmity	171	
Mental health	3	
Cardiac	35	
Blind	14	
Cancer	6	
Illness of long duration (cerebral haemorrhage, rheumatoid arthritis, etc.)	77	
Illness of short duration (post-operative, influenza, etc.)	65	
	—	476

Financial Statement

The County Treasurer has kindly supplied me with the financial statement for the year to 31st March, 1954.

1 Number of helps

At the end of the financial year 125 helps were rendering full or part-time service compared with 134 twelve months previously. The helps render on the average about 12 hours' service per case per week.

2 Number of hours for which helps were paid wages

Details are :—	1953/54	1952/53
Hours—worked	137,982	126,236
„ —travelling, holidays and sick pay ...	28,836	22,545
Total hours for which wages paid	166,818	148,781

Note: For accounting purposes, 1953/54 contains 53 weeks; but even allowing for this, there is a continued rise in the number of hours in 1953/54 compared with 1952/53.

3 Cost of service

Expenditure		Per hour worked 1953/54	Per hour worked 1952/53	
Helps—wages, national insurance, travelling expenses, badges, overalls, etc.		3/0½	2/9¼	
Organisation and supervision (excluding Central Departments)		2½	2	
	£22.403	3/3	2/11¼	£18,571
Income—charges to households	3,390	6	3¼	1,719
Net cost subject to 50% grant	£19,013	2/9	2/ 8	£16,852

Points which should be noted are :—

(a) Helps—wages, insurance, travelling expenses, etc. (including travelling time, holidays and sick pay).
—Note that the cost in 1953/54 is 3/0½d. hour; 2/9¼d. hour being the cost in 1952/53. The rise is due to a wage increase for part of the year and higher rates of national insurance which applied to the full year in 1953/54.

(b) Charges to households.
—Note that recoveries in 1953/54 averaged 6d. hour; 3¼d. hour being the comparable figure in 1952/53. The increased recovery rate in 1953/54 was the result of a revised scale of charges which operated from the early months of the year.

(c) Net cost subject to 50% grant.
—Note the rise—1953/54 £19,013; 1952/53 £16,852.

SECTION 51

Mental Health Service

The report on the Mental Health Service follows the general lines indicated by the Ministry in Circular 1/54.

1. ADMINISTRATION

There has been no material change in the administration of this service during 1953. The Local Health Authority's functions in relation to mental health remain under the immediate control of the Mental Health Sub-Committee, which includes, in addition to members of the Council, a number of co-opted members with special experience in community service.

Mental health work in the community is of a very personal nature, and any suggestion of "officialdom" in the actual handling of cases may well prove to be disastrous. The local health authority's duties (so far as domiciliary care is concerned) are so interlinked with the hospital facilities for mental deficiency and mental illness that there must be a very high degree of co-operation and co-ordination of services between the two types of authority, which both have duties in the broad general field of mental health.

So far as mental health is concerned there has been established, and there continues to be maintained, excellent co-operation between the Regional Hospital Board, through its Hospital Management Committees, and the Local Health Authority. A number of specialist

officers of the Special Area Committee are carrying out part-time duties for the local health and education authorities, and local authority officers assist the hospitals in the supervision of patients who are temporarily absent from hospital either on licence or for some other reason. Personal histories, records, etc., are made freely available between the authorities as occasion demands.

Practically the only staff changes during the year have arisen as a result of the expansion of the occupation centres for mentally defective children. Dr. Gilloran, who acted as deputy certifying officer for the purposes of the Mental Deficiency Acts and also as an approved medical officer for the purpose of the Handicapped Pupils Regulations, resigned at the end of October. Dr. Gallagher, Assistant County Medical Officer, was approved by the Minister of Education for the purposes of the Handicapped Pupils Regulations early in September, following a special course of post-graduate study. Two additional occupation centre assistant supervisors were appointed (Miss Lister in January and Miss Storey in October) to meet the demand for the admission of more children to the two principal occupation centres.

The staff employed in the mental health service, which the Ministry require should be detailed is set out below. It will be noted that the part-time services of certain of the personnel continue to be seconded to us by the Special Area Committee.

Approved Medical Officers: Dr. Fraser, Dr. Gallagher, Dr. Hunter, Dr. Jones, Dr. Perrott, Dr. Thomson, *Dr. Ferguson, *Dr. Braithwaite.

Psychiatrists: Dr. Braithwaite, Dr. Stuart and Dr. Ferguson (seconded from the Regional Hospital Board).

Administrative Assistant: Mr. Froggatt.

Psychiatric Social Workers: (a) West Cumberland—Miss Simpson; (b) East Cumberland—Miss Lamb, seconded from the Special Area Committee in connection with the East Cumberland child guidance centre.

Mental Health Workers: Miss Hall, Miss O'Regan.

Occupation Centre Supervisors: Mrs. Lax, Miss Magee.

Occupation Centre Assistant Supervisors: Miss Cox, Miss Lister, Miss Storey.

Handicrafts Teacher: Miss Cooper.

Duly Authorised Officers: Mr. T. J. Archer, Mr. J. J. Brown, Mr. J. Calvert, Mr. A. Corlett, Mr. W. H. Coulthard, Miss A. E. Fox, Mr. A. Glaister, Mr. J. Gibson, Mr. J. Housby, Mr. J. H. Hocking, Mr. D. W. Jack, Mr. J. D. Messenger, Mr. H. Sewell, Mr. W. J. Wilson.

*Approved for cases in connection with the child guidance centres.

2. WORK UNDERTAKEN IN THE COMMUNITY

(a) Under Section 28, National Health Service Act, 1946

Local health authorities' powers in relation to care and after-care of persons suffering from mental illness and defectiveness were conferred under the National Health Service Act of 1946. These represented a considerable extension of the mental health service and provided the statutory authority to carry out positive work in the community aimed at the *prevention* of illness.

The County Council, as the local health authority, has the *power* (with the Minister's approval) to formulate schemes for the prevention of mental illness and for the care and after-care of the mentally sick, but has no *duties* in this direction unless the Minister of Health so directs. There has, up to now, been no direction to provide this service, and indeed we are not at present in a position to undertake this valuable work. As regards the preventive and after-care aspects of mental disorder, therefore, the Local Health Authority makes virtually no contribution, but the Special Area Committee of the Regional Hospital Board, through the appropriate Hospital Management Committee continues to operate out-patient psychiatric clinics at the three principal hospitals in the county. These clinics are held by the Medical Superintendent of Garlands Hospital and his staff and provide both diagnostic and treatment facilities. As I indicated in my last annual report, one of the most necessary tasks remaining to be undertaken as a community service by the Local

Health Authority is the development of a scheme of after-care for the mentally sick in conjunction with and in amplification of, the service already operated by the hospital. Such a scheme would involve the appointment an additional psychiatric social worker, and the demand for these specially trained workers is much greater than the supply.

The care and after-care of defectives in the community is now a long established service, in which the mental health worker plays a major role, but it is obvious that in carrying out duties in relation to the care of defectives, a considerable list of officers, public authorities, organisations and voluntary associations, many of whom are not directly connected with the local health authority, may be called in to supplement this necessary community service.

Finally, some comment must be made on the indirect influence of the child guidance service under this general heading of preventive and after-care functions. Although this service is primarily the responsibility of the education authority, it obviously makes a useful, if not generally recognised, contribution towards the prevention of mental ill-health.

(b) Under the Lunacy and Mental Treatment Acts, 1919-1930

The duties of a local health authority under these Acts are carried out by officers who are "duly authorised" to take official proceedings in providing care and treatment for persons suffering from mental illness. It is encouraging to note that an ever-increasing percentage of persons requiring treatment for mental disorders voluntarily admit themselves to the mental hospitals, and it is only in those cases involving some legal process that the services of the duly authorised officer are required. These officers in Cumberland are primarily engaged in other duties (registration and welfare services) and their work under the Lunacy and Mental Treatment Acts occupies only a fraction of their time.

During the year under review a total of 280 Cumberland cases were admitted to the mental hospitals. of whom 51 were certified under Section 16 of the Lunacy Act, 1 was admitted as a temporary patient under Section 5 of the Mental Treatment Act, the bal-

ance of 228 being admitted as voluntary patients. Voluntary admissions, therefore, accounted for slightly more than 81 per cent. of total admissions. All but five of the cases admitted from the administrative county were treated at the Garlands Hospital. Discharges of patients from mental hospitals during 1953 totalled 224 (certified 28, temporary 1, and voluntary 195) and 45 patients (of whom 27 were certified) died in mental hospitals during the year.

(c) Under the Mental Deficiency Acts, 1913-38

(i) ASCERTAINMENT

During the year 44 persons were officially "ascertained" as being mentally defective within the meaning of the Mental Deficiency Acts and of these, 39 were "subject to be dealt with" under the Acts. This total of 39 newly ascertained defectives, for whom the Local Health Authority became statutorily responsible, included 16 children found to be ineducable within the scholastic system who were reported by the Education Authority under Section 57 (3) of the Education Act, 1944, 10 boys and girls who were considered to require supervision after leaving school (and who were reported by the Education Authority under Section 57 (5) of the Education Act whilst still in attendance at ordinary schools), 5 cases referred through the courts or by the police and 8 from other sources.

All these cases were included in the total of 293 who were referred to the Mental Health Section for investigation and/or treatment during the year. In addition to those found mentally defective, 94 cases were referred to the child guidance centres because of maladjustment, behaviour disorders, etc., 68 children were reported to the Local Education Authority as being educationally subnormal and in need of special educational treatment in special schools for this type of child, and 10 were recommended to the Education Authority as requiring some type of special tuition in ordinary schools.

(ii) SUPERVISION

The total number of defectives for whom the County Council was responsible at the end of 1953 was 592. Of these 300 were under some form of institutional care, the balance of 292 remaining under the supervision of the mental health section in their own

homes. The task of supervision falls mainly on the shoulders of the mental health workers, and their work in this connection, as I pointed out in my last annual report, is made infinitely more difficult because of the enforced retention within private households of many patients who ought to be accommodated in colonies for the mentally defective, but for whom beds are simply not available. I cannot speak too highly of the manner in which the field workers try to cope with the difficulty of attempting to secure adequate domiciliary care in those many cases where the size or composition of the family unit, coupled with the complication of the presence of an anti-social or difficult defective or one of low grade, plainly points to the need for institutional control and care.

It is interesting to analyse our figures of defectives under community care. In 1948 there were 194 defectives under some form of home supervision by Cumberland officers (72 under guardianship, 99 under statutory supervision and 23 under voluntary supervision); by the end of 1953 the total had increased to 292 (49 guardianship cases, 207 under statutory supervision and 36 under voluntary supervision). This, of course, does not mean that the incidence of mental deficiency in the community has increased to this extent, but is merely an indication of the greater awareness of this social problem followed by a more active programme of ascertainment. In comparing actual numbers under the various types of supervision between 1948 and 1953, there is a decided decrease in the number of patients under guardianship (72 in 1948, 49 in 1953), and on this matter comments are made in the next section. What is most noticeable is the fact that the number of cases under statutory supervision (which means in fact that the patients are defectives who are "subject to be dealt with" under the Mental Deficiency Acts) has doubled within the space of five years.

It is also worth while reporting on the general incidence of mental deficiency in Cumberland by comparison with England and Wales as a whole. In 1929 an inter-departmental committee estimated that there was a total of 7.34 per 1,000 defectives in the community, an estimate which was in 1947 regarded as conservative by an authority on mental deficiency, who

thought that the true incidence was not less than 10 per 1,000 of the total population. The most recent figure for England and Wales shows an ascertained incidence of 2.98 per 1,000, of whom 2.60 were "subject to be dealt with" under the Acts. Cumberland figures at the end of 1953 reveal an ascertained incidence of 2.75 per 1,000, of whom 2.60 were "subject to be dealt with" by the local health authority which is exactly the same, pro rata to population, as for the whole of England and Wales.

Until the introduction of circular 5/52 by the Ministry of Health in January, 1952, all patients admitted to mental deficiency hospitals were "certified" and legally detained. As a result of this circular it is now possible to admit patients to hospital without legal formality for temporary periods of up to 2 months' duration. This scheme of short term care has been and continues to be of untold benefit to parents in tiding over temporary crises, such as the sudden illness of the mother of a defective child. During the year 21 defectives were admitted under these temporary (and voluntary) arrangements to Dovenby Hall Hospital, and here I must place on record our indebtedness to Dr. Ferguson, Medical Superintendent of Dovenby Hall Hospital for his co-operation in this and in many other matters.

Quite apart from solving the many critical situations which arise in households which include a defective within the family unit, the scheme has enabled many parents to have actual experience of the benefits which accrue to the patient even after a comparatively short experience of the training and socialisation which is available in colonies for the mental defective. It is not surprising, therefore, that a period of short-term care is often followed by a request from those responsible for the care and welfare of a defective, for readmission on a more permanent basis.

The task of domiciliary supervision of defectives in the community is considerably lightened by the knowledge that a sudden acute emergency can usually be taken care of by the admission of the defective to hospital for a short stay. There is strong feeling among the vast majority of workers in mental health circles that a more comprehensive scheme of voluntary admission to mental deficiency hospitals should be

given legal authority. I feel sure, however, that the Royal Commission, which has been appointed to enquire into the existing law and administrative machinery in relation to mental illness and mental deficiency, will give serious consideration to this question.

In concluding this section, I will merely record that two adult defectives, one male and one female, have been detained in prison as a place of safety within the meaning of the Acts, for more than six months—in each case because suitable hospital accommodation has not yet become available. Both patients came before the Whitehaven Magistrates' Court, and, being found to be defective and guilty of the offences with which they were charged, the magistrates wished to make orders for direct admission to institutional care under Section 8 of the Mental Deficiency Act, but were unable to do so because suitable accommodation was not available. It was deemed to be in the patients' interests and desirable for the protection of the general public to detain both patients in some place of safety until they could be properly dealt with. The tragedy is that no place of safety other than the prison was available, and that both patients after six months are still waiting transfer to a hospital for defectives.

(iii) GUARDIANSHIP

There were 49 patients under statutory guardianship at the end of the year. This number is five fewer than the corresponding figure for 1952, the decrease being the result of 4 deaths and the transfer of one patient to institutional care. Only 3 of the 49 cases under guardianship were under 16 years of age, and in these cases the Local Health Authority makes a weekly grant towards maintenance and a quarterly payment to assist with clothing. The percentage of patients who are considered suitable for guardianship is quite small, and includes tractable, easily managed, adults of medium grade, who will never be able to support themselves, or be capable of leading an independent life in the community, together with a very limited number of children who have good homes and whose parents are capable of training them in good habits and simple occupations.

So far as Cumberland is concerned, the guardianship provision in past years has been used to a much

greater degree than is general throughout the country. In 1948, for instance, there were 72 patients under guardianship within the county and it is obvious that in many cases guardianship was only a " second best " solution which was applied very frequently in the 1930's because admission to hospital for some reason was not possible. The inevitable consequence is, as I pointed out last year, that not only are defectives under this form of care themselves getting older, but the average age of guardians is disturbingly high. This means, of course, that many of the guardians are now so old as to be unable properly to fill the role of guardian. When a guardian dies there is an ever-increasing difficulty in finding some other relative to take over the onerous task of providing continual and adequate care for the defective.

No new cases were admitted to guardianship during 1953 for the simple reason that it was not possible to find persons who were willing to accept patients under guardianship conditions. If this provision is to continue the conditions must be made much more attractive to the guardian. There must, I think, be a very generous financial reward for providing continual and adequate care and training for the defective; and, in addition, there must be easily available some form of institutional care to which the patient can be admitted at very short notice, and if necessary for long periods, in cases of illness of the guardian, illness or deterioration in the defective and in certain other circumstances.

(iv) OCCUPATION AND TRAINING

The duty which is imposed by the Mental Deficiency Acts upon local health authorities in this direction is " to provide suitable training or occupation for defectives who are under supervision or guardianship," with the proviso that the local health authority shall be under no obligation to provide training or occupation in any particular case if it satisfies the Board of Control that there are adequate reasons for not so doing.

Occupation and training are usually provided in one of three forms. The most important is by the establishment of what are generally known as occupation centres which the younger defectives attend in similar fashion to the primary school, preferably on a full-

time basis on five days per week, but where training is on the practical rather than on the academic side. Many of the younger defectives, because of their inherent condition, are most in need of a period of "socialisation" and the curriculum of an occupation centre, therefore, includes habit training, sense training, physical training, speech training, in addition to hand work, music and movement, training in simple domestic tasks, etc. Secondly, assuming that training at an occupation centre has been undertaken successfully during the period when the defective child would normally have attended school, and also assuming that the defective continues to be unable to maintain himself or herself in even the simplest of paid employment, there should be established what are known as industrial centres. This type of centre is really a form of workshop where defectives can be occupied in the manufacture of such articles as brushes, mats, basket work, etc. At these centres they are fully occupied during working hours, receive adequate supervision and are able, under close supervision, to produce saleable work. To this extent industrial centres should be almost self-supporting, and it may even be possible to pay the defective a small wage for his or her labour. Lastly, training can be offered to defectives in their own homes where more comprehensive and communal facilities are not practicable either geographically or because of some physical condition in the defective which prevents travelling to a group centre.

In a county like Cumberland with a density of population of something in the region of one person per five acres, the practical difficulty of providing facilities for the training of defectives in properly equipped centres or even in small groups, is almost impossible for the whole of the county area. Quite considerable progress has, however, been made during 1953 as regards the provision of occupation centres, mainly for the younger defectives. At the time of my last annual report one whole-time centre (5 days a week) was in operation at Wigton, and this centre, although small and handicapped by the inadequacy of its accommodation, is doing a most useful job of work in catering for the training needs of juvenile defectives within reach of Wigton, and from as far afield as Aspatria and Silloth.

West Cumberland was served by part-time centres at Whitehaven (on 3 days a week) and at Maryport (on the other 2 days each week). Both buildings were too small and the premises generally were very unsatisfactory. The building at Whitehaven which had been used as a day nursery was closed for that purpose in June, and it was quite obvious that with comparatively little structural alteration it could readily be adapted as an occupation centre for defectives. The Ministry of Health agreed to the change of user, and so, after the necessary adaptation, which was largely to provide adequate toilet and sanitary accommodation, it was finally brought into use as a whole-time occupation centre. This meant the closing down of the former part-time unsatisfactory centres at Whitehaven and Maryport. It also meant that all the children from both centres could have the benefit of whole-time, as distinct from part-time, training in much more suitable accommodation and surroundings. The building is single storied, which means that the difficulties encountered at the former centres with defectives climbing stairs, were overcome. Larger, lighter and brighter class rooms are now available, and the total capacity of the centre will be about 45 pupils (by comparison with 20 at the part-time centre at Scotch Street, Whitehaven, and 11 at Maryport).

Arrangements were made for the transport of children from districts north of Whitehaven as far as Maryport to the Whitehaven centre by a privately hired bus instead of the public transport which had formerly been used. This private coach has since been re-routed and now travels from Cockermouth to Dearham and Maryport through Workington to Whitehaven. Guides using public transport still escort children from Frizington, Cleator Moor and Egremont districts to the Whitehaven Centre, so that the catchment area of this new whole-time centre extends over a considerable part of the most densely populated area of the county.

There was established nearly 23 years ago a handicrafts class for older female defectives in Workington. The number of defectives who were able to attend this class has gradually dwindled over the years as a result of deaths and admission to institutional care. It did, however, serve a very useful function both in training and in giving these older defectives a social outlet.

Until recently it was held at the home teacher's house on two afternoons each week. It was felt, however, that the scope of this training could be extended by setting aside a room at the new occupation centre at Flatt Walks and inviting the attendance of other defectives, who live within easy reach of the centre. The handicrafts class, therefore, now functions on two full days a week (as against two half days previously). A much larger group is able to attend and the activities of the group have been extended to include in addition to simple handicrafts, training in routine domestic tasks.

The facilities for the attendance of defectives from the county area at the occupation centre at Kingstown, Carlisle, which were gratefully accepted by an arrangement with the Carlisle City Authority, have not worked out as satisfactorily as was originally hoped. During the year three defectives have been in attendance at the Kingstown centre. One was withdrawn by the parents because of the time spent in travelling to and from the city, and an adolescent epileptic male defective was excluded from the centre because he became too difficult to manage. There now remains at the Kingstown centre only one Cumberland defective under training, and in this case his attendance is restricted to the three days in the week when public transport is available to carry him to and from the centre.

At the end of 1953 136 defectives, who were under supervision or guardianship, were considered suitable for some form of training either in occupation centres, industrial centres, or by peripatetic home teachers. Of these, 47 were actually receiving training, all at occupation centres. The next move in bridging the gap between those requiring and those receiving training in the community must, I think, be the appointment of a teacher who is free to travel, not to single homes to give individual training, but to undertake the training of defectives in small groups for one or two sessions each week in those districts of the county which have a suitable demand for this approach. By this I mean that there are in the county pockets of population such as Millom, Penrith, Keswick, and Alston where there are a few defectives urgently in need of training, but in insufficient numbers to justify the setting up even of a part-time occupation centre.

Briefly then, so far as occupation centres are concerned, the present Wigton centre can be said to cater for the needs of the Wigton district, Aspatria and Silloth, but the present centre is inadequately accommodated in what is virtually one medium sized room, which allows no grouping of the defectives under training, and every effort must be made to secure more desirable accommodation in the very near future. The new Whitehaven centre at Flatt Walks will probably be adequate for the needs of West Cumberland (excluding the districts south of Egremont) for some time to come. Apart from building or acquiring some form of semi-residential centre to cater for the rest of the county area, I cannot foresee when the demand in any particular locality will be sufficient to justify the opening of another centre. Industrial centres, I think, are quite out of the question so far as Cumberland is concerned, because even in the most thickly populated districts of West Cumberland, I do not think there will be within the foreseeable future a sufficient demand for this form of provision to make it an economic proposition.

3. INSTITUTIONAL TREATMENT

At the end of 1953 there were 592 defectives for whom the County Council was responsible, and of these 300 were either in institutions or on licence therefrom as follows:—

	1953	1952
In the area of the Newcastle Regional Hospital Board:—		
Dovenby Hall Hospital, Cockermouth	204	202
Durran Hill House, Carlisle	7	7
Aycliff Hospital, Heighington, Darlington ...	7	4
Morpeth and Northgate District Hospital ...	5	1
Lemington Hall, Alnwick	2	2
General Hospital, West Hartlepool	2	2
Prudhoe and Monkton Hospital, Prudhoe ...	1	1
Bishop Auckland Institution, Durham ...	1	1
In other Regions:—		
Milnthorpe Hospital, Kendal	32	33
Royal Albert Hospital, Lancaster	20	19
Lisieux Hall, Chorley	3	4
St. Mary's Home, Alton, Hants	2	3
Hortham Colony, Almondsbury, Bristol ...	2	1
Coleshill Hill, Birmingham	1	1
Monyhull Hall, Birmingham	1	1
Totterdown Hall, Walton-on-Thames ...	1	1
St. Raphael's, Barwin Park, Herts	1	1
House of Help, Bath	1	1
Stanley Hospital, Ulverston	1	—

Under the jurisdiction of the Board of Control:—		
Rampton Hospital, Retford, Notts	3 ...	6
Moss Side Hospital, Maghull, Liverpool ...	3 ...	2
	300 ...	293

I pointed out in my last annual report that the County Council, as the responsible local health authority, was unable to carry out its statutory duties under the Mental Deficiency Acts for securing the admission of defectives to institutional care (or guardianship) if supervision at home was considered to afford insufficient protection. This most unhappy situation has not improved, and there is ever increasing anxiety about the desperate shortage of hospital accommodation for the mentally defective throughout the country as a whole.

At this stage, and before looking at the local implications, I feel that some comment must be made on this problem from its national aspect. In considering the question, not only must the needs of the patient be borne in mind, but also the immeasurable effect which the presence of a low grade or anti-social defective has on the lives of other members of the family unit. Here we have an aspect of the National Health Service which has shown no alleviation of the problem since 1948. Indeed the waiting lists for hospital accommodation for defectives are longer than ever.

In July, 1948, in England and Wales 3,933 defectives were awaiting admission to suitable institutions, but by the end of 1953 this figure had increased to 8,521. It is of little comfort to distressed and anxious relatives that (to quote the Parliamentary Secretary to the Ministry of Health in a recent statement in the House of Commons) " another 3,000 beds would be made available for the mentally deficient within the next 3 years." The waiting list has increased by 4,588 since July, 1948, and assuming that the planned increase of accommodation is brought to fruition within the three year period and that during the same period the upward trend of admission suddenly flattens out (which is most unlikely), there will still be more than 5,000 defectives awaiting proper care.

This then is the gloomy prospect throughout England and Wales. The problem is not simply one of

bricks and mortar. The recruitment of staff, and particularly student nurses, is probably an even more pressing problem than that of building. Indeed there are many beds (the latest official figure we have is 2,145 at the end of 1952) which could be brought into use very quickly if staff were available. The problem of staffing mental deficiency hospitals did not arise before 1939. In fact, there were at that time waiting lists for staff vacancies at most mental deficiency hospitals.

Many reasons for the falling off in recruitment to mental deficiency nursing have been advanced, and all carry some weight. These include allegations of poor pay and service conditions, the unattractive nature of the work, the comparative isolation of the hospitals themselves and the influence of easily attainable and perhaps more attractive employment. I suggest, however that one of the most important and irreconcilable factors in the low recruitment rate of student nurses is the sharp decrease in the birth rate particularly between 1920 and 1935. During this period the total number of births (male and female) decreased throughout England and Wales by 41%. Girls normally enter the nursing profession as students at about 18 years of age so that the bulk of new entrants as student nurses in 1938 would be born in 1920 when female births throughout England and Wales totalled 466,812. By 1934, the total number of females born had fallen to 280,768, so that in 1952 there were roughly 40% fewer eighteen year old girls available for any type of employment. Even if the nursing profession was attracting entrants in the same proportion as during the years immediately preceding the war, the birth rate between 1920 and 1934 indicates that for every 100 girls entering nursing in 1938, no more than 60 would be doing so in 1952. The graph of the general birth rate suggests that the shortage in actual numbers of girls of an age suitable for entering into nursing training is likely to continue for some years to come. No appreciable increase in the birth rate occurred until 1942, and so it is probable if employment in general is maintained at the present level, that there will be no appreciable increase in recruitment to nursing until about 1960.

Turning now to the position in Cumberland, it will be seen from the table at the beginning of this section

that there was an insignificant increase in the number of defectives under institutional care at the end of the year (300 as compared with 293 at the end of 1952). The number of new admissions during 1953 (totalling 16) was a much higher figure than for many years past. Five patients died in hospital during the year and four were discharged.

Of much more concern is the *waiting list* for institutional care which unfortunately continues to increase at a quicker rate than does the provision of additional accommodation. The following table analyses the waiting list position at the end of 1953, the corresponding figures for 1952 being in brackets.

	Under 16	16 years and over	Total.
1. **In urgent need of institutional care.**			
(a) Cot and chair cases ...	8 (7)	— (1)	8 (8)
(b) Ambulant low grade cases	12 (13)	3 (5)	15 (18)
(c) Medium grade cases	19 (15)	7 (7)	26 (22)
(d) High grade cases ...	1 (1)	5 (2)	6 (3)
	40 (36)	15 (15)	55 (51)
2. **Not in urgent need of institutional care.**			
(a) Cot and chair cases	2 (2)	1 (1)	3 (3)
(b) Ambulant low grade cases	6 (8)	11 (6)	17 (4)
(c) Medium grade cases	7 (8)	18 (12)	25 (20)
(d) High grade cases ...	2 (3)	6 (5)	8 (8)
Totals ...	57 (57)	51 (39)	108 (96)

I feel that I must stress one or two points which arise in the actual compilation of the table shown above. Firstly, a division has to be made between "urgent" and "non-urgent" cases to comply with the Minister's statistical requirements. Obviously the extent of urgency varies over a very wide range, and in any particular case the degree of urgency may change very quickly, not because of any sudden material alteration in the character or conduct of the patient, but because of changes in the amount of care and control which is available within the home, as for example by the illness or even death of the person who is largely

responsible for the defective's welfare. Secondly, in dividing our total waiting list into the two arbitrary groups of the " urgent " and " non-urgent," the former group has been reduced to minimal proportions, and in all cases the word " urgent " has been interpreted in its very strictest form.

In spite of severe pruning, therefore, the waiting list at the end of 1953 was greater than it has ever been in Cumberland, and is exactly 50% bigger than it was two years ago. The fact that additional accommodation through the good offices of the Newcastle Regional Hospital Board has become available at Dovenby Hall Hospital provides some amelioration of the problem. I must, however, point out that in spite of the admission of a good number of our most urgent cases to the new wards at Dovenby, the list of cases still awaiting admission at the end of 1954 will in all probability contain as many names as did the list of two or three years ago.

It is fully realised that the actual provision of adequate and properly staffed institutional accommodation for mental defectives is not the concern of the Local Health Authority, and also that the Regional Hospital Boards are fully alive to the present appalling position. In concluding this section, therefore I can only summarise what has been written in previous reports as follows:-

(1) It is difficult to imagine a situation within the compass of the National Health Service Act which causes more human misery than does the enforced retention of certain types of defectives in private households.

(2) The waiting lists for institutional accommodation for defectives are **increasing** both locally and throughout the country.

(3) Local health authorities are unable to carry out their statutory duties because of the inadequacy of hospital accommodation, and courts of law are frequently unable to take what is considered by them to be suitable action for the same reason.

(4) The whole framework of the local health authorities' mental deficiency service is in jeopardy because an efficient domiciliary service is dependent upon adequate hospital facilities.

REPORTS AND NOTES ON INDIVIDUAL SERVICES AND OTHER MATTERS

Dental Service

Orthopaedics

Prevention of Blindness

Spastics and Epileptics

Venereal Disease

Cancer

Infectious Diseases

Food and Milk

Housing

Water and Sewerage

Dental Service

The Senior Dental Officer makes the following comments on the dental service for 1953:—

"In the report for 1952, in connection with the improvement in the staff position, it was stated that it was proposed to complete the full-time establishment of nine dental officers in the near future. The appointment of Mr. Hayes to a full-time post, instead of part-time, should have accomplished this on September 1st, but the sudden death of Mr. Askew altered the position and at the time of writing no replacement has been obtained. The position has still further deteriorated with the resignation of Mrs. Ferguson.

"As will be realised, this unsettled state of things makes it impossible to organise the Maternity and Child Welfare service in a satisfactory manner. In school work the children are inspected in school and those requiring treatment are notified and subsequently dealt with. In other words, the problem is one that can be assessed and, with adequate staff, completely covered owing to the fact that the children are accessible in large groups and the dentist can *go to the children* for inspection. With pre-school children the picture is reversed, the children have to *go to the dentist* for inspection, and, of course, this means that the mother has to take time off from her many duties merely to be told, as often happens, that the child's teeth are all right.

"Naturally in many cases the mother carries out the inspection herself if she is sufficiently concerned, and in just those cases which would benefit from early treatment, decides that there is nothing wrong with the teeth. A year or two ago routine inspection was tried in Cumberland for these cases, but the loss of time from failure to attend resulted in the experiment being abandoned. There is no doubt that where there is a shortage of staff with all its consequent evils it is most unwise to embark on new schemes even of proved value when it is impossible to carry out fully the commitments which already exist.

"Similar difficulty is experienced with expectant and nursing mothers who are often very reluctant to spend time attending for inspection unless they are

aware that treatment is necessary, and to many the only basis for this is toothache. Still it must not be taken that all cases are of this type—there are many that come with a real desire to have all the conservation treatment possible and attend with unfailing regularity, but alas, these are but oases in the desert, though they are certainly most refreshing to meet. It is feared that a great part of the population is not very tooth conscious, though progress has been made since 1920 when the writer was asked by a mother who had been told her boy, aged 5, required treatment, 'Is he not too young to have false teeth?'

"When it is pointed out that out of nearly 1,000 forms issued to expectant mothers only 200 were returned, while of these 40 failed to keep appointments, it will be realised that what has been said is not without foundation. What is the answer? At the present time there does not appear to be one. To indulge in propaganda to make people more tooth conscious when the available staff cannot cope with the work already in hand would be the height of folly. It seems that the only thing to do is 'Wait and See' in the hope that more settled conditions will come to pass in the dental profession and that it will be possible to maintain a staff adequate to deal with *all* the dental responsibilities which fall upon the local authority.

"This would mean a relatively large staff, and it is doubtful if any authority would approve the increase of establishment involved with the rating position as it is, even if it were possible to fill the vacancies created. However, the increase in establishment of dental officers to 10 from October, 1954, which has been approved, is a move in the right direction even if staff is not available at the moment. It is hoped, too, that the salary increases recently awarded by the Industrial Court to dental officers may stimulate the recruitment of public dental officers, but again it is all a matter of 'Wait and See.'

"Regarding the table showing numbers provided with dental care, it will be noticed that the figures for mothers do not correspond with those given above in relation to the sending out of notices. This is because a certain number have been referred by doctors, midwives, etc., while some have requested treatment them-

selves. This difference is of interest, as it shows that the public is beginning to realise, though slowly, the facilities which are available, and while in most cases it is toothache which is the real cause of treatment being sought, full treatment is carried out whenever possible."

(a) Numbers provided with dental care.

	Examined.	Needing Treatment.	Treated.	Made Dentally Fit.
Expectant and Nursing Mothers ...	210	205	205	74
Children under five	232	232	232	98

(b) Forms of dental treatment provided.

	Extractions	Anaesthetics. Local	Anaesthetics. General	Fillings	Scalings or scaling and gum treatment.	Silver Nitrate treatment.	Dressings.	Radiographs.	Dentures provided Complete	Dentures provided Partial
Expectant and Nursing Mothers ...	599	116	33	123	19	—	128	14	65	36
Children under five	457	20	169	41	—	20	36	4	—	—

Orthopaedic Treatment

The statistics for the year 1953, which follow, do not differ materially from those of the previous year. The work in the county orthopaedic clinics continues as in former years, even though there is not so much active orthopaedic work done in them as some years ago.

These clinics are becoming more after-care and preventive, rather than genuine orthopaedic clinics—due to a great measure to the large weekly orthopaedic clinics now held at various hospitals in the county. Even so the county clinics continue busy with the supervision of apparatus, such as walking irons, spinal braces, etc., and the treatment by exercises of postural defects and other disabilities.

The follow-up and after care of patients on discharge from the hospital is one of the duties of the orthopaedic physiotherapists, and it is very much hoped that this work may substantially increase, particularly among orthopaedic cases discharged from our local hospitals. One of the consultant orthopaedic surgeons makes considerable use of our county services in this respect, the other does not.

From the surgeons' point of view the county clinics admittedly lack the accommodation and equipment to be found in the hospitals for immediate X-rays, plasters, instrument makers in attendance, etc. Nevertheless, our county orthopaedic service ought to play a very useful part in any complete orthopaedic scheme for supervising long standing cases, and particularly for West Cumberland patients who have received hospital treatment in Carlisle, by saving long journeys for review. The two types of clinics—hospital and county —should run in co-operation, and not in competition, and so ease the crowded hospital waiting rooms.

Our two orthopaedic physiotherapists, both having motor transport, could fit into their other duties an appreciable amount of domiciliary visiting for such matters as the repair of plasters, and for reporting to the orthopaedic surgeons, *if desired*, on factors affecting the progress of rehabilitation.

Other patients from our clinics requiring long term hospital treatment for surgical tuberculosis, etc., are almost all admitted, as in the past, to the Shropshire Orthopaedic Hospital, and the children are admitted to the Ethel Hedley Hospital at Windermere. Both hospitals are most helpful, and always do their best to admit urgent cases with the least possible delay.

The earliest possible treatment of congenital deformities in babies, such as club feet, wry neck, etc., is often carried out by home visits before the babies are many days old, and the early spotting of congenital dislocation of the hip makes all the difference in the final result of treatment. This very early treatment does now happen in a great number of cases, but I should like to feel that our co-operation with the general practitioners could be so close in this matter that every baby with even a suggestion of deformity could be referred to the county orthopaedic scheme in the first instance.

Orthopædic conditions affecting children under five years of age.

Bow leg and knock knee	203
Flat foot	64
Congenital deformities of feet	40
Congenital defects otherwise	6
Spina bifida	3
Poliomyelitis	12
Torticollis	9
Cerebral palsy	4
Congenital dislocation of the hip	5
Birth palsy	4
Scoliosis, lordosis and kyphosis	5
Coxa vara	1
Postural defects, feet and otherwise	119
Other conditions	12
	487

Tuberculosis of bones and joints.

	Adults	School Children	Under 5 years.
Totals	96	30	2

Adult non-tubercular cases.

Poliomyelitis	23
Arthritis	9
Scoliosis, lordosis and kyphosis	13
Congenital dislocation of the hip	11
Slipped epiphysis	2
Flat foot	8
Osteomyelitis	23
Vertebral disc protrusion	20
Hallux valgus and deformed toes	6
Injuries (including fractures)	14
Cerebral palsy	7
Congenital defects	11
Postural defects, feet and otherwise	3
Perthes disease	1
Synovitis and other joint conditions	5
Spina bifida	1
Other conditions	7
	164

General Statistics.

Number on aftercare register, 1-1-53	718
New cases during 1953	195
Cases renotified after previous discharge	3
Number of cases removed from register	171
Number remaining on register at 31-12-53	745
Number attending surgeons' clinics	746

Attendance at aftercare clinics	1,672
X-ray examinations during 1953	107
Waiting for X-ray	59
Home visits	299
Plasters applied	56
Surgical boots and appliances supplied	278
Appliances supplied from stock	10

Hospital Admissions.

Name of Hospital.	In hospital at 1/1/53.	Admitted during year.	Discharged.	In at 31/12/53
Ethel Hedley Hospital, Windermere ... (Including school children).	21	14	22	13
Shropshire Orthopædic Hospital, Oswestry ... (In addition to 8 long-stay cases, 32 patients were admitted and discharged after short-stay review).	4	8	6	6
Cumberland Infirmary, Carlisle ... (Including school children).	—	9	9	—

The above admission figures refer only to patients admitted to hospitals from our county clinic waiting lists. I have no information about other hospital admissions or waiting lists.

Prevention of Blindness and Care and Aftercare of Blind or Partially Sighted Persons

In the immediately preceding years the County Welfare Officer in his section of this report has dealt in very great detail with the arrangements for the care and aftercare of the blind, and has reviewed the agency arrangements between the County Council and the Cumberland and Westmorland Home and Workshops for the Blind.

No material change has taken place during 1953, and all that would appear to be necessary in this year's report, so far as the medical aspect of blindness is concerned, is to draw attention to the table which follows, drawn up on lines desired by the Ministry.

A. Follow-up of Registered Blind and Partially Sighted Persons.

	Cause of Disability.			
	Cataract.	Glaucoma.	Retrolental Fibroplasia.	Others
(i) Number of cases registered during the year in respect of which para. 7 (c) of Forms B.D.8. recommends.—				
(a) No treatment	20	5	1	30
(b) Treatment (medical surgical or optical)	15	2	—	6
(ii) Number of cases at (i) (b) above which on follow-up action have received treatment	6	1	—	5

B. Ophthalmia neonatorum.

(i) Total number of cases notified during the year	Nil
(ii) Number of cases in which.—	
(a) Vision lost	)
(b) Vision impaired	) Nil
(c) Treatment continuing at end of year	)

It will be noted from the table that ophthalmia in the new-born has to all intents and purposes ceased to exist, and in our experience in this county the tragedies which used to happen from this particular disease no longer occur.

I also wish to draw attention to the fact that one case of the somewhat rare condition of retrolental fibroplasia occurred during the year. Reference is made to this in another section of this report.

One case of congenital blindness came to notice during the year in which the mother had contracted German measles during the early months of pregnancy. We have been for a considerable period now co-operating in a national investigation into the effects of German measles and certain other of the exanthemata occurring during pregnancy in the development of physical or mental abnormalities in the child. As it happens this is the only instance up to date in which the mother is known to have contacted one of these conditions during pregnancy (our figures are of course small), in which the mental or physical development of the child has been affected.

Epileptics and Spastics

The Ministry ask for such information as is available as to the incidence of these conditions in the area, together with a brief review of the facilities available under the local health services for persons suffering from these handicaps, and the degree to which these facilities are being co-ordinated with the diagnostic and treatment centres and the welfare services.

Spastics.

This matter has recently been very much in the public eye, and from the educational angle has been considered by the Education Committee, and has, I understand, been discussed at the North Eastern Council of Education Committees.

With regard to children, we know, I think, fairly well the extent of the problem.

The following table shows the position in respect of school children:—

Spastic children attending primary schools ...	14
Spastic children attending special residential schools for physically handicapped	2
Spastic children attending special residential schools for educationally sub-normal girls ...	1
Spastic children in Ingwell Special School ...	1
Spastic children discharged from residential schools as unsuitable for treatment	1
Spastic children being considered for special residential schools, including 1 receiving home tuition and 1 or 2 receiving speech therapy ...	4
Spastic children classified as ineducable ...	3

With regard to children under 5 years of age, we only know of 3 children with a serious degree of spasticity. These cases have not yet been fully explored.

The Medical Director of the Percy Hedley School for Spastics, Newcastle, kindly consented to visit the area during the early summer of 1954 to see about 8 children to assess their fitness for admission to a special residential school for spastics. Progress in this matter has been so recent that it is almost impossible to be more precise. It is clear that the Percy Hedley School for Spastics in Newcastle with 12 beds at the moment for spastic children, is not nearly big enough to cater for the whole of the North-Eastern region, and I understand that its expansion is under consideration.

With regard to adolescent and adult spastics, to be quite honest we have not at the moment the remotest idea of the incidence of this condition among the adult population. It so happens that some months ago instructions were issued to all the district nurses and health visitors in the county to let us have in confidence the names, ages, and addresses of any persons known to them who were spastics or epileptics, together with a note of the severity of the condition so far as they could assess it. The result up to date has been almost negligible. Whether this means that the number of spastics and epileptics in the area is extremely limited or whether it means that they have not yet come to light I do not know. I suspect that the latter alternative is the true answer in the case of epileptics.

As is noted in another part of this report, the Council are applying during this summer for authority to adopt the Minister's model scheme for welfare services for handicapped persons other than the blind and the deaf and dumb. When this has been approved, the first step will be to attempt to compile a register, and in this by no means easy task I imagine that a number of agencies, including this department, will be involved.

The problem of the spastic or the epileptic does not end when the child leaves school, in fact I suppose it is correct to say that the major problem then begins, and it is abundantly clear from the recent circular (26/53) from the Ministry, on "The Special Welfare Needs of Epileptics and Spastics" that this thought is very much in their minds.

Epileptics.

We cannot at this stage claim to have done more than scratch at the surface of the problem, but we have submitted for specialist examination, including examination by electro-encephalograph, a limited number of suspected epileptics. The Welfare Department have at present 4 men and 3 women in epileptic colonies, and 5 men and 2 women are being maintained in Part III. Accommodation in the county.

The Education Department maintain a few epileptic children in epileptic colonies or special schools.

VENEREAL DISEASES

I am indebted to Dr. H. J. Bell, Consultant Venereologist, for the following extracts from his report to the Special Area Committee :—

" The following table shows the total numbers of fresh infections (acute gonorrhoea and early syphilis), and the total attendances at clinics of the Cumberland Infirmary and Whitehaven Hospital :—

	Early V.D. Infections.		Total Attendances.	
Year.	Carlisle.	Whitehaven.	Carlisle.	Whitehaven.
1945	156	53	5181	2304
1946	201	81	5274	1821
1947	139	38	3764	1362
1948	94	28	3473	944
1949	69	44	3212	995
1950	47	48	3089	1396
1951	43	9	2436	1141
1952	29	8	2081	870
1953	19	7	1924	976

" The column of ' Early V.D. Infections ' is no longer an accurate indicator of morbidity, but serves merely to illustrate a trend. As pointed out before, a large number of patients infected with gonorrhoea never come to the clinic at all, but are treated by their own general practitioners. Thus, the incidence of gonorrhoea in Cumberland can only be guessed at. My impression is that gonorrhoea is on the increase, a finding reported also from other parts of the country.

" The situation regarding early syphilis remains unchanged. The disease is represented by a sporadic case here and there. Cases of later syphilis with complications referable to the nervous system and the heart are much more common, and show a slight numerical increase.

" The commonest condition under treatment is non-gonococcal urethritis—a disease not represented in the table of ' Early Infections.' Once again, the epidemiological importance of this disease must be a matter of guesswork since, like gonorrhoea, it is so often treated by the local doctor in his surgery. At the clinics it is twice as common as gonorrhoea. It has become the priority problem—and the most difficult puzzle—in all clinics such as my own. In itself, it is not an impor-

tant disease, because it is so susceptible to treatment by a variety of modern antibiotics. For all that, it is important because it gives rise to such distress among married couples especially. It is a sexual disease: whether it is always a venereal disease is another matter. Our ignorance of its aetiology means that it is a difficult matter to ' explain away ' when faced with the anxious patient. Two or three years ago there was evidence that the causal agent was a virus or an organism of the pleuro-pneumonia type. This evidence has now become suspect. My own clinical impression is that the disease is most common among those engaged in farming; it is no more than an impression and is the less valuable because I work in a rural community. At the moment, nobody knows how or where the infection originates. It is usually a form of venereal disease, but occasionally it is obviously not so. At the best, we congratulate ourselves that it is curable, at the worst, we admit our ignorance of its aetiology. The problem remains.

" Turning to the table showing total attendances, it will be noted how the figure for Carlisle has continued to decline. I have explained previously that V.D. clinics in agricultural areas are losing their function as treatment centres and have tended, more and more, to become diagnostic centres. For instance, many cases of late syphilis are referred by general practitioners for the sake of diagnosis: thereafter, treatment is often carried out in its entirety by the general practitioner himself, although the patient is referred back to the Consultant periodically for further advice or routine tests. I welcome the co-operation of practitioners in the treatment of cases of syphilis, because treatment is a shared responsibility. Where gonorrhoea is concerned, I am not so happy that patients should be treated at the doctor's surgery. The treatment of gonorrhoea should involve two patients, a man and a woman. The patient the doctor treats is the man, and seldom is any attempt made to trace the woman and treat her. Therefore, although the method may be personally convenient to both the man and his doctor. it is detrimental from an epidemiological point of view, since there remains the reservoir of infection in women left without treatment. This may be one of the reasons why gonorrhoea is still on the increase.

Congenital Syphilis.

"I am pleased to report that no case of infantile (congenital) syphilis was discovered in Cumberland last year. Nine cases of congenital syphilis in older children and adults were diagnosed and brought to treatment. Luckily, the complication of neuro-syphilis was absent in all of them.

"The total number of pregnant women sent for investigation and treatment was 15. Only one of these patients was notified under the County Council Scheme for Rhesus and Wassermann testing. All the others were referred from hospital ante-natal clinics and by general practitioners working independently of the scheme. I would like to re-iterate the value of all these agencies for detecting syphilis in families. Their importance is not merely in the prophylactic treatment of the unborn. The report of a positive Wassermann in an individual gives me the opportunity to investigate an entire family and detect early other cases of syphilis, congenital or acquired, in that family. Recently a report from a private practitioner led to the discovery of latent syphilis in the mother, asymtomatic neuro-syphilis in the father, and congenital syphilis in one daughter of three years of age. Reports of this kind, obviously, are of inestimable value to me."

The only point I would like to add to what Dr. Bell has said above is that during the year 508 blood specimens from ante-natal patients booked for confinement in their own homes were taken. These specimens were examined for the Rh. factor and by the Wassermann test. Reference is made elsewhere in this report to the Rh. factor position. With a regard to the Wassermann tests, only one of the 508 specimens is shown as a doubtful Wassermann reaction and this is the one case to which Dr. Bell refers in the preceding paragraph.

CANCER

Deaths from cancer during the year amounted to 352 which shows a slight decrease on the figures for the previous year. Details of these deaths by age groups and sanitary districts are given below.

Cancer Deaths during 1953—By Sanitary Districts

	Males	Females	Total
Urban Districts :			
Cockermouth	3	5	8
Keswick	5	1	6
Maryport	11	18	29
Penrith	9	10	19
Whitehaven	21	23	44
Workington	24	20	44
Aggregate of Urban Districts	73	77	150
Rural Districts :			
Alston	1	1	2
Border	17	20	37
Cockermouth	16	11	27
Ennerdale	28	25	53
Millom	14	17	31
Penrith	7	8	15
Wigton	18	19	37
Aggregate of Rural Districts	101	101	202
Whole County	174	178	352

Cancer Deaths during 1953—By Age Groups.

	0-45		45-65		65+		All Ages Totals	
	M.	F.	M.	F.	M.	F.	M.	F.
Urban Districts ...	8	12	32	22	33	43	73	77
Rural Districts ...	6	12	32	31	63	58	101	101
Whole County ...	14	24	64	53	96	101	174	178
	38		117		197		352	

The hospital side of this matter is entirely one for the Special Area Committee. Our part as a health authority is confined to the provision of domiciliary nursing, domestic help, and after-care, under section 28 of the Act. We are, of course, also responsible for transport.

I am indebted to the secretary of the East Cumberland Hospital Management Committee for the following figures relative to the out-patient clinics and hospital admissions at the Cumberland Infirmary. It will be noted that these figures include figures for areas outside the administrative county :—

Patients Attending Out-Patient Clinics

	First Attendance	Other Attendances	Totals
County	111	637	748
City	123	598	721
Other Districts ...	61	219	280
Totals	295	1454	1749

Patients Admitted to Hospital

County	198
City	149
Others	46
	393

During 1953, 427 patients were *registered* as new cancer cases of which 243 were patients from the administrative county. Dr. Milligan, Consultant Radiotherapist at the Cumberland Infirmary, is of opinion that the above registration figures represent between 50% and 60% of the cases of malignant disease. Dr. Milligan gives me the following figures about treatment by radiotherapy :—

Patients receiving x-ray therapy for the first time	383
Total attendances by patients (Carlisle and Workington)	4,823

Dr. Milligan estimates that approximately 30% of the attendances were from West Cumberland, and he estimates that about 25% of the patients having x-ray therapy were for non-malignant conditions.

INFECTIOUS DISEASES

No major epidemic of the more serious infectious diseases occurred during tne year. The number of cases of whooping cough at over 700 was the highest for some years, and there were a considerable number of cases of measles chiefly in Workington borough and Maryport urban district and the Border rural district.

Thirty cases of poliomyelitis were notified during the year, of which 21 were mild or non-paralytic. At one time there was a fear that we were on the verge

of a major epidemic but most fortunately this fear did not materialise.

There were a few cases of Sonné dysentery. There were no cases of diagnosed or even suspected smallpox, and, continuing our good fortune for several years past, we have no case in the enteric fever group.

No cases of diphtheria was notified. There have in fact only been two notified cases in 4 years.

The records of mortality from the commoner infectious diseases in respect of the past few years, are as under :—

1945/1952 inclusive	Scarlet Fever	nil
1953		nil
1945/1952 inclusive	Diphtheria	5
1953		nil
1945/1952 inclusive	Enteric Fever	1
1953		nil
1945/1952 inclusive	Measles	20
1953		nil
1945/1952 inclusive	Whooping Cough	27
1953		nil
1945/1952 inclusive	Diarrhoea (including gastritis and enteritis) ...	90
1953		12

The adaptation of the isolation block at the Cumberland Infirmary, and of Galemire Isolation Hospital is still, for financial reasons, incomplete, although much has been done at both of these hospitals to bring the accommodation for infective cases into line with modern practice.

With the small number of infectious diseases calling for hospital isolation it has been possible to use a considerable proportion of the beds for other purposes.

The following table shows the incidence of infectious diseases in the County during 1953.

NOTIFICATION OF CASES OF INFECTIOUS DISEASES IN THE COUNTY OF CUMBERLAND DURING THE YEAR 1953

District.	Scarlet Fever.	Whooping Cough.	Dip.	Measles.	Pneumonia.	Meningococcal Infection.	Acute poliomyelitis Paralytic.	Acute poliomyelitis Non-paralytic.	Acute encephalitis Infective.	Acute encephalitis Post. infectious.	Dysentry.	Food Poisoning.	Erysipelas.	Chicken Pox.	Enteric Fever.
Urban Districts															
Workington	42	96	—	842	20	1	—	2	1	—	2	3	17	263	—
Whitehaven	21	102	—	105	21	2	1	2	—	—	—	—	6	—	—
Cockermouth	—	12	—	8	1	—	—	—	—	—	—	—	—	—	—
Keswick	1	2	—	63	—	—	—	1	—	—	—	—	—	—	—
Maryport	14	54	—	464	10	1	—	1	—	—	1	2	—	—	—
Penrith	9	5	—	104	7	—	—	—	—	—	—	—	1	—	—
Rural Districts															
Alston	—	51	—	2	3	—	—	—	—	—	—	—	1	1	—
Border	35	43	—	425	5	1	3	7	—	—	1	2	1	—	—
Cockermouth	15	27	—	252	9	2	—	1	—	—	—	4	3	—	—
Ennerdale	29	118	—	53	19	2	—	1	—	—	1	2	1	—	—
Millom	7	80	—	95	4	1	—	—	—	—	—	—	4	—	—
Penrith	17	10	—	227	16	1	1	1	—	—	—	—	1	—	—
Wigton	14	102	—	206	15	—	4	5	—	—	—	—	10	—	—
TOTALS	204	702	—	2846	130	11	9	21	1	—	5	13	45	264	—
1952	278	388	—	662	79	9	9	3	—	—	45	7	39	115	—
1951	240	679	2	4616	139	17	24	10	2	—	89	10	44	348	—
1950	280	497	—	619	129	—	22	6	—	—	121	—	25	104	—

INSPECTION AND SUPERVISION OF FOOD.

Foods other than Milk.

The report of the County Analyst is not included as this has already been circulated to the County Council. No epidemic of food poisoning of any significance occurred in the county during the year under review.

Milk.

Last year I drew attention to the fact that the Ministry of Agriculture and Fisheries had decided to declare Cumberland and Westmorland and certain parts of the adjoining counties of Lancashire and Yorkshire a free testing area, the target being that somewhere in the autumn of 1955, the area will be declared an attested area. This means that no cattle can enter the area which have not passed the tuberculin test.

This is the first large area in England to be so dealt with and it is something of a distinction. I note that at the time of writing there is a proposal to approach the Ministry of Agriculture for exemption to the arrangements to allow cattle, presumably from Eire, to enter the area through the Port of Silloth. I imagine that this refers to cattle brought in for slaughter for human consumption and the exemption would, I imagine, not allow cattle to be brought in in this way for entry into the dairy herds in the area. I understand that about 10,000 cattle are brought into Cumberland annually as store cattle for ultimate slaughter. This entry, if approved, will not directly complicate milk producing herds and represents a very small proportion of the total cattle population of the county, 242,000.

All this means that the time is approaching when the incidence of tuberculosis in this area due to bovine infection will cease. Tuberculosis of bovine infection is mainly responsible for tuberculosis of the bones and joints and parts of the body other than the lungs, but a recent memorandum from the Ministry on the prevention of tuberculosis reminds us that bovine infection does play some part in pulmonary tuberculosis in the human race. In this connection it is interesting to recall that while the notifications of pulmonary tuberculosis in the county have fluctuated substantially over

the years the notifications of non-pulmonary tuberculosis which, as I have said, are primarily due to bovine infection have, apart from 1947 and 1949, remained steady around the 45-48 mark for a number of years. The deaths from non-pulmonary tuberculosis in 1952 reached the lowest figure on record with 9 compared with 32 in 1947. The figures for 1953 at the time of writing are not yet available, but one hopes that they will be at least as good as for 1952.

All this means that the more severe types of non-pulmonary tubercle have been decreasing in incidence and that the mortality has fallen in line with this. What has to be remembered is that tuberculosis, for example of the bones and joints, can be a most distressing and disabling affliction and treatment may cover years. All this underlines the significance of the fact that we are approaching the stage at which non-pulmonary tuberculosis should vanish from the area.

With regard to the sampling of milk for tubercle, you will recall that, following upon the passage of legislation transferring responsibility for the control of milk supplies from local health authorities to the Ministry of Agriculture, it was decided at conferences held in the county to consider the situation to limit the sampling for tubercle in milk, which for many years had been carried out on a very extensive scale in the county, to the sampling of ungraded milk consumed in the county without having been pasteurised. The number of samples taken under these new arrangements has necessarily been very much lower that during the years of what may be called unrestricted sampling. During 1953, 688 samples were taken from ungraded supplies under the arrangements outlined above. These were submitted to the biological test, i.e., guinea pig inoculation for tubercle, and the percentage found positive for tubercle out of these 688 samples was *nil*. This is a remarkable and gratifying result. Last year I included a table showing the results of sampling for the previous ten years and during this period, the average of samples found positive for tubercle was about 1%. These percentage figures are small but by no means insignificant. For the ten years the sampling has shown that an average of something like ten herds a year have yielded samples positive for tubercle. To

have reached the stage when out of 688 samples none have been found positive for tubercle is extremely satisfactory and reflects great credit on the Divisional Inspector of the Ministry of Agriculture and on all others concerned. The fear expressed in many quarters that the introduction of a bonus for tuberculin tested milk and the introduction of the attested herd policy might mean the gravitation of reacting animals into ungraded herds just does not seem to have materialised.

The districts from which the 688 samples were taken during 1953 were as follows :—

Sanitary District.	Number taken for biological examination for tubercle. 1953	1952	1951
Rural			
Alston	—	1	—
Border	—	1	—
Cockermouth	181	171	86
Ennerdale	48	93	93
Millom	175	130	37
Penrith	26	45	34
Wigton	218	153	207
	648	594	457
Urban			
Cockermouth	—	—	—
Keswick	3	4	21
Maryport	16	22	5
Penrith	—	—	1
Boroughs			
Whitehaven	11	12	11
Workington	10	9	21
	688	641	516

The above table lends itself to some obvious comments, but I leave these to others.

With regard to the bacteriological cleanliness of our school milk supplies, as I noted last year, I have no information.

I continue to be greatly indebted to the Divisional Inspector of the Ministry of Agriculture for his close co-operation with this department. He gives me the following figures dealing with cattle slaughtered during the year and certain other matters. The figures for 1952 are shown in brackets. One very interesting point is that one of the cows slaughtered under the Tuberculosis Order found to be suffering from tuberculosis of the udder, actually in a tuberculin tested herd, proved to

be affected with *avian* tuberculosis. Avian tuberculosis is of course tuberculosis originating from birds, usually domestic poultry. This is a very rare condition and the Divisional Inspector tells me that only four, or possibly five previous cases have ever before been recorded in Britain.

Clinical Inspection of Dairy Herds.

Class of Herd	No. of Herd Inspections	No. of Cattle examined	No. of Cattle dealt with under the Tuberculosis Order
Tuberculin Tested	1,152 (1,076)	59,100 (52,835)	1
Accredited ...	21 (71)	938 (1,901)	—
Non-Designated ...	2,867 (2,523)	60,173 (44,731)	16

Tuberculin Testing of Tuberculin Tested Herds.

No of cattle tested	79,304 (71,940)
No of reactors	129 (145)

Tuberculosis (Attested Herds) Scheme.

No. of attested herds	3,810 (3,314)
No. of supervised herds	66 (41)

Pasteurised Milks.

There are still only three pasteurising plants in the administrative county, one in Egremont and two in Millom. As before, our sampling duties in respect of pasteurised milks are carried out through the co-operation of the sanitary inspectors of the district councils concerned, for which co-operation we are very grateful. Seventy samples were taken during the year and submitted to the phosphatase and methylene blue tests. Of these, sixty were satisfactory to both tests and ten unsatisfactory (seven were unsatisfactory to the phosphatase test but satisfactory to the methylene blue test and three were unsatisfactory to the methylene blue test while being satisfactory to the phosphatase test).

HOUSING

I am indebted to the County Architect for the following notes on the housing position as affecting County Council employees:-

"The County Council continue to erect houses mainly for firemen, police officers and district nurses, and during the past year have completed twenty-seven houses. A further forty-four were under construction at the end of the year.

The hope that prices would be more stable has proved unfounded as wage, transport and fuel increases have inevitably resulted in higher building costs. Whilst every effort is being made to keep the price of the houses low, it should be appreciated that the cost of an isolated house must inevitably be higher than one of a large number built at the same time.

Fire Service

No new houses were completed during the year, but a start has been made with ten houses adjoining the new station at Hensingham, two houses at the Dalston depot and the conversion of a house at Penrith into three flats.

Police Service

Twenty two were completed during the year and a further twenty three are under construction. The new type of rural station is now occupied, and though smaller than the original type, the tenants have expressed complete satisfaction with its compactness and convenience.

Nursing Service

Four houses were completed during the year and four were under construction. Economy in price has been effected by slightly reducing the area of the original plan.

Smallholdings

One house at Nether Welton has been completed and though it was the cheapest house built during the year, it has proved completely satisfactory. Two substandard dwellings whose economic life expired many years ago will be demolished when the tenants have found other accommodation.

Education

No new houses have been completed during the year, but two are under construction.

General

Many houses for all services have been fully modernised by the installation of bathrooms, hot water and electricity and other minor improvements. Further work of this nature is being planned for the coming year."

This schedule has much of interest and is well worth careful study. I think a particularly interesting figure (A.4) is the estimated number of sub-standard houses which could be repaired and made fit. It will be seen that the estimated total of such houses in the County is 10,906, divided as between 9,863 in the rural areas and 1,043 in the urban areas. It is a little difficult to understand why more use is not made of the provisions for improvements and conversions in the Housing Act, 1949.

It has been suggested that various factors may explain this, one being the difficulty of complying with the standards of fitness laid down by the Ministry. Another is that the increase in the permitted controlled rent for an improved dwelling, or conversion, may not be sufficient adequately to recompense the owner for the capital expended. There are no doubt other reasons, one possible one being the hesitation of housing authorities to make grants to persons whom they may not consider to be in need of financial assistance, but, whatever the reasons are, comparing A.4 with D.1, 2 and 3 in the schedule, it is apparent that in most areas of the County little use is made of the opportunities provided by legislation for the improvement of sub-standard properties. Bearing in mind some of the excellent conversions made under the Housing (Rural Workers) Acts, 1926 to 1942, this, I think, is regrettable.

The Housing Repairs and Rents Bill—before Parliament at the time of writing—will amend the Housing Act, 1949, so as to render the improvement and conversion of sub-standard houses more attractive to the private owners. The Ministry are asking local housing authorities to make more use of their powers, which it is expected will receive wide publicity when the new bill is placed on the statute book.

It is, I think quite true to say that if really good conversions can be effected on sub-standard houses, the cost to the housing authority is much less, allowing in both cases for the appropriate government assistance, than the building of a similar number of new houses. A well converted sub-standard house may not be so attractive as a new house in a building area, but it is surely vastly better than nothing. I have heard it said, although housing is only incidental to a County Council, and therefore this view is second-hand, that some

HOUSING RETURNS FOR THE COUNTY OF CUMBERLAND

For

YEAR ENDED 31st DECEMBER, 1953.

	Alston R.D.C.	Border R.D.C.	Cockermouth R.D.C.	Ennerdale R.D.C.	Millom R.D.C.	Penrith R.D.C.	Wigton R.D.C.	Total for R.D.C's in County	Whitehaven Borough	Workington Borough	Cockermouth U.D.C.	Keswick U.D.C.	Maryport U.D.C.	Penrith U.D.C.
Population 1931	2678	26049	21250	28235	12582	12016	22058	134868		24691	4784	4635	12382	9065
1951	2300	29848	19560	29631	13424	11500	23733	129996	24624	28620	5234	4660	12237	10490
A. 1—Total number of occupied dwelling houses in the district	879	7909	5893	8463	4260	3453	7001	37858	7150	8419	1908	1579	3927	3103
2—Total number of occupied dwelling houses subject to Demolition Orders, Closing Orders or Undertakings	8	82	27	74	1	—	28	220	47	16	37	1	160	—
3—Estimated number of houses (exclusive of above) which are unfit for habitation and cannot be made fit at a reasonable cost	170	605	460	2024	130	400	375	4164	600	300	not available	20	402	396
4—Estimated number of sub-standard houses (exclusive of above) which could be repaired and made fit	380	950	1870	3225	929	1000	1509	9863	550	150	„	100	153	90
5—Number of houses found to be overcrowded	30	49	58	23	23	240	26	449	5	300	„	—	—	94
B. WAITING LISTS. Total number of valid applicants on Council's waiting list exclusive of those living in houses under A2 and 3 above	15	705	257	358	270	No Wtg. List	468	2073	500	1600	—	174	267	150
C. NEW HOUSES COMPLETED DURING THE YEAR— 1—By or for the Council— For aged persons	—	—	4	—	—	—	—	4	—	—	—	—	—	—
For agricultural workers	—	—	8	—	8	2	4	22	4	—	—	—	—	—
Flats	—	—	—	—	—	—	—	—	2	—	—	—	—	—
General purpose houses	16	36	58	123	81	28	108	450	266	115	50	10	198	28
2—Private building	2	27	19	10	9	11	18	96	21	—	5	6	4	12
Total	18	63	89	133	98	41	130	572	293	115	55	16	202	40
D. 1—Number of houses for which application was made by private persons for Improvement Grants under the Housing Act, 1949	—	22	8	13	2	3	4	52	1	1	1	—	—	6
2—Number of houses for which grants were approved	—	19	8	—	—	2	3	32	—	—	1	—	—	6
3—Number of houses where improvements were carried out and grants paid	—	12	5	—	—	—	4	21	—	—	1	—	—	2
4—Number of houses purchased or taken over by the Council with a view to improvement or conversion	—	7	22	—	8	—	—	37	—	—	—	—	—	—
5—Number of houses improved by the Council— (i) With grant	—	—	—	—	—	—	—	—	—	—	—	—	—	—
(ii) Without grant	—	—	—	—	1	—	—	1	—	—	—	—	—	—
E. TEMPORARY ACCOMMODATION Number of families occupying camps and temporary buildings	—	81	2	—	2	—	41	126	—	—	—	—	—	76
F. HOUSING PROGRAMME— Estimated number of houses to be built during the ensuing year— (i) Private	2	30	35	10	6	15	16	114	25	45	NA	10	2	10
(ii) Council	52	80	142	200	66	24	70	634	270	382	40	41	128	34

housing authorites are feeling the financial strain of their housing schemes, and one would have thought that if that were the case the conversion of sub-standard houses to bring them into line with modern standards would have presented an opportunity to housing authorities to continue the remarkably good work they are doing at the minimum of cost to the rates.

WATER AND SEWERAGE SCHEMES

(a) Water

During the past year the number of water supply schemes submitted either for approval of the County Council or for grant aid has been small compared with the previous year, largely due to the fact that Local Authorities have been obliged to devote most of their time to the preparation of schemes within the framework of the "Spens" report summary.

Following the receipt of the "Spens" report the County Engineer has been invited by some authorities in the county to participate in discussions and consultations on their water proposals. This will enable the County Council to appreciate proposals eventually put to them and help to secure the effective co-ordination of water supply schemes. In particular, the County Engineer was invited by the Maryport U.D.C. to prepare a factual report on five possible sources of supply including abstraction from the River Derwent at Stainburn, which was suggested to him by the Workington Water Committee. The County Engineer has also participated in discussions between Maryport U.D.C. and the Ministry of Housing and Local Government, to secure provisional engineering approval and offer of financial assistance for a new water scheme selected by Maryport from those detailed in his factual report to Maryport of March, 1953.

In the Border Rural District the County Engineer thought that the augmentation of supplies from new gravity sources, independent of Carlisle, might have been considered, but it is understood that the District Council favour the "Spens" proposals for augmenting supplies in conjunction with Carlisle. Whilst this report was in preparation, discussions took place with the Corporation officials.

The Sewerage and Water Supply Schemes Committee consider that if they are to be in a position to make recommendations to the County Council on grants under the Rural Water Supplies and Sewerage Acts, 1944 and 1951, they must have the fullest information possible on water resources in any given area, so that proposals put forward may be considered in relation to the district as a whole, and shown to be the most satisfactory and economical possible.

Orders under the Water Act, 1945

Workington Borough Council applied for an order under Section 33 of the Water Act, 1945, to enable them to abstract from Crummock Water, 4 million gallons per day instead of the 2 million gallons per day authorised by the Workington Corporation Act, 1899. The Minister, having considered a report by one of his Senior Engineering Inspectors, following a public local inquiry, has decided not to make the order.

The Council was also informed concerning an order which the Minister proposes to make under Section 9(2) of the Water Act, 1945. to transfer the water undertaking of the Harrington and Distington Joint Water Committee partly to the Workington Corporation and partly to the Ennerdale R.D.C.

Schemes

Appendix "A" shows the schemes dealt with during the year, the estimated capital cost and, where appropriate, the amount of grant which has been provisionally allocated.

APPENDIX "A"

Scheme submitted by. 1	Name of Schemes. 2	General Outline. 3	Estimated Cost. 4	Grants Ministry 5	Grants County 6	Remarks. 7	Stage at 31/3/1954 8.
Alston-with-Garrigill R.D.C.	... Comprehensive Water Supply Scheme.	... —	£109,000	£50,000	£45,000	Both Ministry & C.C. ... grant include The Raise portion of the Scheme.	Grant Approved
Do.	... Nenthead Water Supply	... To utilise Hard Edge source, provide new chlorination plant and extend distribution.	... £12,750	£3,500	£3,500	C.C. have recommended ... that scheme be designed to permit of incorporation in future extension of Comprehensive Scheme as far as possible.	Subject to Col. 7 approved by the C.C. as a sound and desirable expedient.
Do.	... Springfield Reservoir	... —	£6,300 (1951) £6,763 (actual on completion)	£2,500	£1,900	C.C. to reconsider grant ... aid on actual cost of Scheme.	Scheme completed but see remarks Col. 7.
Border R.D. Council	... Roughton Gill Water Supply.	... Extended additional ...supply.	... £75,000 (1950) £80,000 (1954)	£10,000	£10,000	—	Works proceeding.
Millom R.D. Council	... Underhill Water Scheme	... Improvement of supply to Green Road and Underhill.	... £2,336	—	—	—	Approved by C.C.
Do.	... Silecroft Water Supply	... Tank at Kirkbank	... £2,939 (actual)	£1,600	£550	—	Completed Feb., 1953.
Wigton R.D. Council	... Blencogo Water Supply	... 4 in. main from High Scales to Leegate House to be incorporated in future works based on Overwater supply.	... £1,880	—	—	—	Approved by C.C.

(b) Sewerage

The sewering of rural localities being dependent on the existence of sufficient water supplies, a number of schemes submitted for approval during the year are not likely to proceed for a year or two. The schemes envisaged in the county development plan are taking shape, and will enable housing programmes to be undertaken in accordance with the plan.

The largest single scheme considered was the Wigton Town sewerage scheme. In 1947, the provision of a domestic sewer distinct from a separate trade sewer to deal with effluent from the British Rayophane Factory, was estimated to cost £62,560. By July, 1952, the estimated cost of a revised scheme had increased to £133,700. Tenders were taken in in 1953 and the cost then found to be £192,000. In 1947 it was anticipated that a 25% grant under the Distribution of Industry Act, 1945, would be available and the County Council provisionally agreed to an equivalent grant under Section 307 of the Public Health Act, 1936.

Grants under the Distribution of Industry Act, 1945, were discontinued in June, 1952, and the Ministry are dealing with the revised scheme under the Acts of 1944 and 1951. At first a grant of £35,000 was indicated but recently this has been increased to £50,000.

In the absence of sufficient details to appreciate the progressive increases in the anticipated cost of the scheme, the County Council were in some difficulty and felt unable to deal with the grant position. There have been further discussions and it is expected that the difficulty will be resolved.

A summary of the schemes dealt with during the year, appears as Appendix "B" hereto.

APPENDIX "B"

Scheme Submitted by 1	Name of Scheme 2	General Outline 3	Estimated Cost 4	Grant		Remarks 7	Stage at 31/3/1954 8
				Ministry 5	County 6		
Border R.D. Council ...	Crosby on Eden sewerage scheme.	—	£9,500	£1,250	£1,250	—	Scheme complete.
Ennerdale R.D. Council ...	Egremont —Braystones outfall sewer.	—	£27,000	—	—	—	Approved in principle by C.C.
Wigton R.D. Council ...	Wigton Town sewerage scheme.	Extensive new works and replacement of existing sewer.	£133,700	£35,000	£15,600 (Under Public Health Act, 1936, based on original Estimate).	C.C. grant may be reconsidered on submission of additional information.	Commenced 1/1/54.
Do. ...	Oulton and Woodside sewerage and sewage disposal scheme.	—	£10,750	—	—	—	General approval of scheme subject to consideration by R.D.C. of improvement suggested by County Engineer.
Do. ...	Drumburgh sewerage and sewage disposal scheme.	—	£6,650	—	—	—	Approved in principle by County Council.
Do. ...	Glasson sewerage and sewage disposal scheme	—	£10,300	—	—	—	Approved in principle by County Council.

PULMONARY TUBERCULOSIS

AND

DISEASES OF THE CHEST

TUBERCULOSIS

As a preamble to the reports from the consultant chest physicians which follow, it will be useful to give certain figures for the whole county.

Notifications

The following table shows the notifications in Cumberland for 1953 and the preceding years:-

Year	Pulmonary	Non-Pulmonary
1948	195 ...	45
1949	222 ...	32
1950	231 ...	48
1951	267 ...	46
1952	259 ...	45
1953	286 ...	46

Deaths

Deaths from pulmonary tuberculosis for 1953 amount to 44 which is almost the same figure as the previous year. Deaths from non-pulmonary tuberculosis at 4, represent a new low level and compare with an average of 19 for the past seven years.

The following table shows the deaths from pulmonary and non-pulmonary tuberculosis in Cumberland for 1953 and preceding years:-

Year	Pulmonary	Non-Pulmonary
1948	116 ...	15
1949	107 ...	25
1950	101 ...	15
1951	80 ...	11
1952	43 ...	9
1953	44 ...	4

Distribution

The distribution of deaths from pulmonary tuberculosis by areas has been received from the Registrar General as follows:-

Urban Districts	Deaths	Death rate
Cockermouth	—	—
Keswick	1	.21
Maryport	2	.16
Penrith	1	.10
Whitehaven	6	.24
Workington	9	.31
Aggregate of Urban Districts ...	19	.22

Rural Districts	Deaths	Death rate
Alston	—	—
Border	3	.10
Cockermouth	5	.26
Ennerdale	12	.42
Millom	3	.21
Penrith	—	—
Wigton	2	.09
Aggregate of Rural Districts ...	25	.19
Total for the administrative county	44	.20

It may be of interest to compare the deaths from pulmonary tuberculosis in East and West Cumberland for the past few years, and these figures are set out in the table which follows:-

Year	Total	East Cumberland Total	East Cumberland Percentage	West Cumberland Total	West Cumberland Percentage
1948 ...	116	31	26.7%	85	73.3%
1949 ...	107	36	33.6%	71	66.4%
1950 ...	101	22	21.8%	79	78.2%
1951 ...	80	18	22.5%	62	77.5%
1952 ...	43	7	16.3%	36	83.7%
1953 ...	44	7	15.9%	37	84.1%

The percentages given in the above table represent the percentage proportion of the total deaths occurring in the county during these years, allocated between East and West Cumberland. The actual figures of deaths, apart from the percentages have, of course, to be read in conjunction with the population figures of the two areas of the county which are as follows:-

East Cumberland ...	82,430
West Cumberland ...	133,670
	216,100

These population figures are the Registrar General's estimated mid-1953 figures.

Expressed as a rate per 1,000 population, the deaths from pulmonary tuberculosis during 1953 worked out as follows:-

East Cumberland	...	.08
West Cumberland	...	.28

The detailed reports from the consultant chest physicians which follow, cover the position very fully but one or two general comments may be of value. The first is that deaths from pulmonary tuberculosis in England and Wales fell during 1953 from 9,335 in 1952 to 7,911 for 1953 which represents a fall in deaths of some 15%. Naturally, one could have wished that we could have shared in this fall, but in fact as noted above, our total deaths have remained stationary although at a very low figure compared with previous years.

It is I think generally recognised by all concerned with the tuberculosis problem that the fall in the total deaths from pulmonary tuberculosis represents a prolongation of life of the patients concerned by chemotherapy and other modern lines of treatment. It is of course accepted that this necessarily means the existence in the community of an increasing number of cases of tuberculous persons in the chronic fibroid and usually infectious stage who in former days would have died. In these persons the disease has, as a result of modern treatment been arrested, but not cured, and I think, although all the experts may not agree with this, that the increasing number of chronic fibroid cases with a positive sputum may well present a problem as foci of infection to their contacts for some years ahead.

With regard to the surgical treatment of pulmonary tuberculosis so far as minor forms of surgical treatment such as the phrenic crush are concerned, it appears to be, at least in some quarters, coming to be regarded as less commonly necessary than has been until recently considered to be the case. Treatment by major thoracic surgery appears to be rising in importance and therefore the opening by the Regional Hospital Board of the thoracic centre at Seaham Hall to which patients from the Special Area are admitted, has been very welcome. It is hoped and expected that during the current year substantial leeway will have been made up in the waiting list for major surgical treatment.

The reports from the consultant chest physicians follow.

EAST CUMBERLAND

(Dr. W. Hugh Morton, Consultant Chest Physician)

Introduction

Chest disease needs little introduction in a Public Health report. Not only is pulmonary tuberculosis one of the most common serious diseases of the lungs, but it is an infectious one.

Other lung diseases such as bronchiectasis, chronic bronchitis in the aged, and pneumoconiosis can result in as much disability and crippling as pulmonary tuberculosis, and can entail serious economic problems to the individual and the factory where he is working, and to the community.

Pulmonary cancer, previously relatively uncommon, has recently been the subject of considerable publicity, even in the lay press.

Tuberculosis

Notifications

The notifications for the East Cumberland area dropped to a new low level during 1953. You will recall that last year I hinted that the peak notification rate had been reached for this area, and that our figures would, in future, tend to fall into line with the lower notification rates generally throughout the country.

I would again stress the value of periodic chest X-ray examination of the ordinary individual, as there is still undoubtedly a reservoir of unsuspected cases infecting other members of the community. During the past year a larger proportion of our new cases have been comparatively early and amenable to treatment, and in spite of exhaustive enquiries no family history of tubercle has been discovered in more than 80% of these. The mass radiography unit continues to prove an asset in discovering such cases, but I believe that, in spite of our reasonably intensive propaganda, there is still a considerable lack of appreciation of the value of a periodic chest examination by a comparatively small, though not unimportant, percentage of the community.

The fear that he has the disease may in itself make the patient postpone a consultation with his own doctor until it is too late. A recent survey in London

suggested that this might be the vital factor in our inability to check the spread of the disease more rapidly, and this factor in itself emphasises that our propaganda must be still more vigorous. Not only must we continue to press for frequent chest x-ray examinations but we must also press forward with all methods of therapy, both medical and surgical, so that the fact that more and more patients are made well and restored to normal working life, will convince the ordinary individual in the street of our methods, both diagnostic and therapeutic. No matter how successful we may be, however, in treatment, the importance of everyone in the community being able to appreciate the value of periodic chest overhaul must be emphasised.

Not only must an individual realise that the early discovery of the disease means cure and a quick return to normal working life for him, but he should also appreciate that by neglecting to consult his doctor, or have a periodic chest examination, he is, by spreading the disease, inflicting grave damage on his fellow citizens.

Co-operation between the general medical practitioners and ourselves continues to be of a very high standard.

Table 1 gives the number of notifications throughout England and Wales for the years 1947 to 1952.

Table 1.

Year.	No. of Notifications.
1947	61,800
1948	62,600
1949	63,300
1950	59,000
1951	49,440
1952	41,904

Table 2 shows the notifications in East Cumberland for 1952 and 1953, and for the whole of the county for the preceding four years.

Table 2.

Year.	Pulmonary.	Non-Pulmonary.
1948	195	45
1949	222	32
1950	321	48
1951	267	46
1952	79	20
1953	63	18

Deaths.

The number of deaths has remained stationary in this area for 1953. This is not unexpected and I anticipate that this number will continue to be at the same level for a further two years yet.

Modern anti-biotics, whilst they make a valuable contribution to the cure of patients, also result in what must, unfortunately, be only temporary improvement in patients who are suffering from very extensive and incurable disease. The result is that the lives of such patients are prolonged, and one would say that in the absence of modern anti-biotics many of the deaths which occurred in 1953 would have occurred in earlier years.

Fortunately, the proportion of new cases coming to our notice and classified as advanced, and also the proportion of cases still in an infectious state on completion of treatment, both show a steady decline.

Last year I commented on the mortality rates in both sexes. The age and sex distribution of the new cases of tuberculosis discovered during 1953 are set out in tables 3 and 4 and applies to patients from the Eastern Division of the County of Cumberland.

Table 3.

Number of new cases for 1953, showing sex and age period distinction for East Cumberland.

	Under 5	5-15	15-25	25-35	35-45	45-55	55-65	65 plus
RESPIRATORY								
Males ..	1	—	7	6	7	6	4	3
Females	—	—	10	5	4	7	3	—
NON-RESPIRATORY								
Males ..	1	1	4	1	—	1	—	—
Females	—	1	3	2	—	2	1	—

Table 4.

RESPIRATORY

Number of new cases for 1953 showing distinction of early and advanced disease, for East Cumberland.

	R.A. 1	R.A. 2	R.A. 3	R.B. 1	R.B. 2	R.B. 3
Males ...	5	12	5	2	2	8
Females	14	5	4	2	1	3
No. of above respiratory cases referred by M.M.R.						
Males ...	1	5	3	—	—	1
Females	7	1	2	1	—	1

NOTE: "B" cases refer to cases where the organism has been isolated.

I would point out (1) the large number of cases found to have minimal or early disease after passing through the mass radiography unit; (2) that the morbidity rate is higher at a later period of life in males than it is in females; and (3) the comparatively large number of males who have been found to have a positive sputum and are thus infectious. These points emphasise (i) the importance of periodic mass x-ray over-haul, and (ii) the ignorance shown, particularly by males, in estimating the relative importance of early diagnosis and probable cure, and late diagnosis and chronic invalidism with its relative economic problems both affecting the individual and the community in general.

Table 5 shows the deaths from pulmonary tuberculosis throughout England and Wales, and table 6 shows the death rate from pulmonary and non-pulmonary tuberculosis in the Eastern Division of the county for 1953 and for the preceding five years in the whole of the county.

Table 5.

Year.	No. of Deaths.
1948	25,880
1949	23,320
1950	18,750
1951	12,031
1952	9,335
1953	7,911

Table 6.

Deaths from pulmonary and non-pulmonary tuberculosis in Cumberland. **The 1953 figures only relate to the Eastern Division of the County.**

Year.	Pulmonary.	Non-Pulmonary.
1948	116	15
1949	107	25
1950	101	15
1951	80	11
1952	43	9
1953	7	1

Statistics

Table 7 gives the total number of notified cases of tuberculosis, both pulmonary and non-pulmonary, on the East Cumberland Register for 1953.

Table 7.

CLINIC REGISTER AS AT THE END OF 1953—COUNTY OF CUMBERLAND—EASTERN DIVISION.

	Respiratory.				Non-Respiratory.				Totals.				Grand
	M.	W.	Ch.		M.	W.	Ch.		M.	W.	Ch.		Total
Cases on Clinic Register on 1st January, 1953 ...	181	158	10	...	7	17	20	...	188	175	30	...	393
Additions to Register during 1952	37	39	2	...	11	9	3	...	48	48	5	...	101
	218	197	12	...	18	26	23	...	236	223	35	...	494
Removals from Register during 1953	15	17	2	...	3	—	1	...	18	17	3	...	38
Number on Register on 31st December, 1953 ...	203	180	10	...	17	26	20	...	220	206	30	...	456
Number known to have had a positive sputum within the preceding 6 months	41	27	—	...	—	—	—	...	41	27	—	...	68

I would again comment on the number of cases known to have had a positive sputum within the last six months of the year. From table 4 it will be noted that 18 cases, a little under one third of the total number of new cases coming to our notice in the last year, were discovered to have a positive sputum (32% of the new cases compared with 40% for 1952). At the end of 1952 there were 74 County cases on our Register as having had a positive sputum within the last six months of the year; whereas at the end of the year under review the total number of cases known to have had a positive sputum had decreased to 68. About two thirds of these cases come into the category of chronic advanced cases for whom little permanent benefit can be expected from treatment. The remaining third would probably have become non-infectious had full surgical facilities been available. As the new thoracic unit at Seaham Hall only opened in September the full effect of the work done there will not be seen in this table until the end of the current year—1954, when one would expect that this figure will have fallen very much further.

The smaller percentage of new cases with a positive sputum leaves no room for complacency as this percentage merely reflects the operations of our mass radiography unit and intensive diagnostic chest centre work. There is undoubtedly, and I must again emphasise this, a large reservoir of unknown infectious cases in this community.

Contact Examinations

The examination of contacts in its widest sense takes up considerable time at the chest centre. Tables 8 and 9 give the total number of contact examinations for the year.

Table 8.

STATEMENT OF ATTENDANCES AT CHEST CENTRE, CARLISLE, DURING 1953

	East Cumberland.		Carlisle City		North Westmorland		Total		
	R.	N.R.	R.	N.R.	R.	N.R.	R.	N.R.	
1—No. of New Cases seen:—									
Adult Male	249	1	282	—	50	—	581	1	
,, Female	224	—	324	1	46	2	594	3	
Male child	67	2	87	2	16	—	170	4	
Female child	55	1	65	2	10	1	130	4	1.487
2—No. of Old Cases seen:—									
Adult Male	588	9	770	15	103	12	1461	36	
,, Female	647	32	1035	30	107	26	1789	88	
Male child	89	8	191	13	31	2	311	23	
Female child	98	7	162	24	14	4	274	35	4.017
3—No. of New Contacts seen:—									
Adult Male	136	—	167	—	33	—	336	—	
,, Female	231	—	247	—	46	—	524	—	
Male child	192	—	190	—	36	—	418	—	
Female child	188	—	220	—	36	—	444	—	1.722
4—No. of Old Contacts seen:—									
Adult Male	14	—	26	—	8	—	48	—	
,, Female	25	—	37	—	5	—	67	—	
Male child	122	—	282	—	25	—	429	—	
Female child	120	—	312	—	16	—	448	—	992
5—No of cases seen by physiotherapist:—									
Adult Male	50	—	125	—	6	—	181	—	
,, Female	168	—	145	—	4	—	317	—	
Male child	69	—	214	—	20	—	303	—	
Female child	140	—	109	—	6	—	255	—	1056
6—No. of cases of Pneumoconiosis	42	—	—	—	2	—	44	—	44
7—No. of A.P. refills given	1220	—	1737	—	62	—	3019	—	
8—No. of P.P. refills given	1529	—	2858	—	220	—	4607	—	
9—No. of E.P. refills given	54	—	75	—	—	—	129	—	7755
10—Screen examinations only ...	169	—	177	—	3	—	349	—	349
11—Aspirations							132	—	132
12—Domiciliary visits							341	—	341
TOTAL ATTENDANCES ...									17.895

*The number of old and new contacts in Sections 3 and 4 include 1079 old and new contacts who passed through the mass radiography unit, and are included to comp lete the contact figures.

Table 9.

SUMMARY OF CONTACT EXAMINATIONS DURING 1953

	East Cumberland.			Carlisle City			Westmorland.			
	M.	W.	Ch.	M.	W.	Ch.	M.	W.	C.	Total
(a) Total number of new contacts examined in 1953 either at Chest Centre or M.M.R.	136	231	380	167	247	410	33	46	72	1722
(b) Total No. of new contacts attending Chest Centre only		286			368			47		701
(c) No. of old contacts examined during 1953		281			657			54		992
(d) No. of contacts examined through the M.M.R.										1079
(e) Total No. diagnosed as tuberculous	—	—	1	—	2	2	—	—	—	5
(f) No. of Mantoux Tests carried out in 1953		296			609			69		974
(g) No. of contacts vaccinated with B.C.G. during 1953		48			97			9		154

As before, all contacts under the age of 15 are Mantoux tested and those negative after two intradermal tests are given B.C.G. The latter was not refused in any single case during the year.

It was found impossible to extend Mantoux testing to adults, apart from nursing and hospital staffs, because of the otherwise heavy demands on the limited personnel at the chest centre. It is, however, most desirable that contacts of all ages should be Mantoux tested, as even at the age of 20, at least 35% of this age group and perhaps a larger percentage in this area, will have no reaction to the Mantoux test; and as tuberculosis tends to decline the Mantoux test will become increasingly important. Should pulmonary tuberculosis become a rarity, then a positive Mantoux test in a member of the community will be of extreme diagnostic importance and lead us to our cases of tuberculosis.

It is impossible to estimate the percentage of positive reactors in this community as, of course, the people whom we test are a selected group and have already been in fairly close contact with known cases of tubercle. Considerable information will doubtless come to light when the medical staffs of the local authorities commence large scale tuberculin tests in school children.

All contacts are examined radiologically either at the chest centre or through the mass radiography unit and are kept under periodic supervision and are given appointments to attend every four to six months. This is most important, particularly in the strongly positive Mantoux reactors, and I hope it will be possible to pass through the mass radiography unit all school children who are tested later by the local authorities' medical officers.

The expression "contact" is used in its widest sense and during the past year the number of contacts of each notified case has varied enormously. Not only are the immediate family contacts examined but neighbours, and where the case is a school child even the whole school. One such case involved the staff and pupils amounting to 591 and occurred in January, just after the end of the year under review.

All contacts of cases of tuberculosis, both pulmonary and non-pulmonary, notified after death, are investigated in the same way and are retained under supervision.

B.C.G. Vaccination

B.C.G. vaccination continues to be given wherever possible and evidence continues to accumulate of its value in preventing active tuberculous disease. Until now, contacts of definite cases of tubercle and nursing and medical staffs in hospitals have been the only members of the community to whom vaccination has been offered. The current year, however, will see this scheme extended to school children between the ages of 13 and 14, and it is to be hoped that the scheme will also apply in the very near future to infants and children under 5. Not only is routine B.C.G. vaccination in infants less time consuming in that one can dispense with the preliminary Mantoux test and vaccinate right away, but such vaccination of infants would go a long way to reducing the incidence of acute forms of tubercle, such as meningitis, etc., in the under 5's.

Institutional Treatment

The number of beds available for the treatment of pulmonary tuberculosis in the area covered by the East Cumberland Hospital Management Committee is given in Table 10.

Table 10

Institution.	No. of beds.
Meathop	10
Blencathra (Temporary allocation) ...	31
City General Hospital	14
Longtown	23
Cumberland Infirmary	10
Ormside	20

Table 11 gives a summary of the hospital return for the year 1953 in respect of beds under the East Cumberland Hospital Management Committee.

Table 11.

SUMMARY OF HOSPITAL RETURN FOR THE AREA COVERED BY THE EAST CUMBERLAND HOSPITAL MANAGEMENT COMMITTEE.

	Blencathra Sanatorium.	Ormside Sanatorium.	City General Hospital.	Cumberland Infirmary.	Longtown Hospital
No. of patients given:—					
(a) Streptomycin	—	—	—	—	—
(b) Streptomycin & Paramisan	—	28	39	13	37
(c) Isoniazide	—	—	—	—	16
(d) Isoniazide & Streptomycin	—	6	23	14	—
(e) Paramisan	—	—	—	—	—
(f) Adhesion Section	—	—	33	—	—
(g) Phrenic Crush	—	—	52	6	3
(h) P.P. inductions	48	—	40	—	—
(i) A.P. inductions	26	—	15	—	—
(j) Aspirations	—	—	11	—	—
(k) I.N.H/P.A.S./Streptomycin	—	14	12	3	23
No. of patients discharged during 1953—					
R.A. Cases—Quiescent ...	52	25	43	9	36
Non-Quiescent ...	5	11	20	—	3
R.B. Cases—Quiescent ...	54	13	51	9	37
Non-Quiescent ...	57	—	48	12	20
No. of patients—Died	8	—	—	—	1
Non-tuberculous	—	—	4	—	1

NOTE—Figures in this table relate to in-patients in these hospitals.

This table shows the scope of the work done with the beds under our control. There are two points I would bring to your notice. The first is that streptomycin is no longer used alone in chemotherapy, because if it is so used resistance to the tubercle bacilli rapidly develops. Secondly, minor collapse therapy with its ancillary minor surgery, such as adhesiotomy and phrenic evulsion continues to play an important part in treatment. Whilst in selected cases this treatment is excellent, the number of cases so treated will undoubtedly decline as the increasing availability of major surgery facilities will be used in preference. This is not only our experience but would appear to be general throughout the country; indeed, in one area, viz., South Wales Region, no A.P. or P.P. inductions have been done for two years.

Table 12 gives the total number of cases from the Eastern Division of the county admitted to institutions for treatment during 1953.

Table 12

Sanatorium.	Adults.	Children.
Blencathra	... 26	... —
Meathop	... 5	... —
Longtown	... 38	... —
City General Hospital	... 43	... 1
Cumberland Infirmary	... 13	... —
Ormside	... 24	... —

Table 13 shows the waiting list for the whole of the area covered by the East Cumberland Hospital Management Committee.

Table 13.

Section (a) **Sanatorium waiting list as on the 31st Dec., 1953.**

Males.	Females.	Children	Total.
8	9	—	17

Section (b) **Major Surgical waiting list as on the 31st Dec., 1953**

Males.	Females.	Total.
20	23	43

You will note that the waiting list for the ordinary sanatorium admissions is now at a low level, but I would again comment on the lack of beds for the investigation and treatment of non-tuberculous condition, such as bronchiectasis and neoplasm.

There is no waiting list for minor surgery as all cases arising are dealt with as a matter of routine within a week or two.

You will note, however, the considerable waiting list of cases for major surgery. The new thoracic unit at Seaham Hall Hospital opened at the beginning of September, and I append herewith in table 14 the number of cases done there from the date it opened up to the time of writing this report—27th April, 1954.

Table 14.

	East Cumberland.		Carlisle City.		North Westmorland	
	M.	F.	M.	F.	M.	F.
Thoracoplasty ...	4	8	4	7	—	2
Resection	—	—	—	1	—	1
Decortication ...	—	—	1	—	—	—
Extra Pleural Pneumothorax ...	1	—	2	1	—	—
Pneumonectomy ...	—	—	—	1	—	—

It will be noted that in spite of this excellent turnover there is still a comparatively big waiting list for major surgery, and I am afraid it will tend to keep about its present level as modern chemotherapy and other methods of treatment are undoubtedly rendering more and more patients fit for major surgery. I would particularly comment on the very excellent results following both thoracoplasty and extra pleural pneumothorax at Seaham Hall. Whilst there is no doubt that resection in certain cases of advanced tuberculous disease, e.g., destroyed lung or stricture of the larger bronchi is the treatment of choice, thoracoplasty and extra pleural pneumothorax give good results in most lesions limited to upper lobes, and both these latter procedures have a great advantage over partial resection in that the complication of over extension of the remaining lung tissue does not arise. These operations, however, are only one stage in the treatment of pulmonary tuberculosis, although a life saving one as far as many of our patients are concerned.

Care and After Care including Rehabilitation

In addition to the very full contact examinations carried out when a case is notified every effort is made to advise a patient on the hygiene and other measures necessary to prevent the spread of the infection. Contacts are supervised regularly and the patient is admitted to hospital as soon as there is a vacancy, usually within a week or two. Close co-operation is

maintained with the local health authority in the matter of disinfection and alternative housing.

On completion of treatment a patient in this area is not allowed to return to work until we are satisfied he is (i) fit for work; and (ii) non-infectious and consequently not a danger to others. Although every effort is made to make a patient fit to return to his former employment, obviously some types of work are grossly unsuited to a patient who has had pulmonary tuberculosis. Work in the milk, and milk products industry is contra-indicated from the Public Health point of view, while such work as quarrying or long distance transport driving is physically unsuitable. Such patients are interviewed by a rehabilitation panel consisting of representatives from the Ministry of Labour and chest physicians, which continues to meet at the chest centre monthly; at these sessions the full problem is discussed with the patient. Suitable work is either provided or in the case of a patient in the under 40 age group, a course of industrial rehabilitation may be provided at one of the Ministry of Labour's residential colleges. The cost of such a course is defrayed by the Ministry of Labour, and every effort is made to place patients in industry locally when their course is completed.

I would particularly comment here on the number of patients who have decided to go in for nursing, and there is at the present time a considerable number of these training in the major hospitals in the East Cumberland area.

On the patient's return to work very close supervision is exercised, particularly during the first six months; at the training centres this is carried out by the Ministry of Labour medical officers, but the bulk of the patients return to work locally and this supervision is undertaken at the chest centre.

Ambulance Service

Our calls on the Ambulance Service remain high largely because we continue to send patients home before their full periods of graduated bed rest and exercise have been completed, thus enabling us to have a larger turn over in our beds.

OTHER CHEST DISEASES

Bronchiectasis

The following table shows the number of bronchiectasis cases on our register at the end of the 1953; the number of new cases coming to our notice during the year, and the number of attendances for physiotherapy made by patients suffering from this disease.

	East. Cumberland.			Carlisle City.			North Westmorland.		
	M.	F.	Ch.	M.	F.	Ch.	M.	F.	Ch.
On register 31-12-52	21	13	22	27	16	8	9	3	4
New cases during 1953	12	10	6	21	9	7	5	1	1
Total on Register on 31-12-53 ...	33	23	28	48	25	15	14	4	5
No. of attendances for physiotherapy	50	168	209	125	145	323	6	4	26

The results of treatment by physiotherapy continue to be excellent, particularly in those cases, be it adult or child, who regularly carry out their exercises at home at least four to six times daily. The patient who does not do well is the one who does not take the trouble to do these exercises at home and whose clinical and radiological condition shows no improvement after six months.

The following table shows the age and sex distribution of the cases of bronchiectasis at present under investigation and attending here for treatment.

	Under 5.		5-10.		10-15.		15-25.		25-45.		45 & over.		Total.
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
Carlisle City ...	—	2	7	5	1	1	6	9	20	8	20	6	85
East Cumberland	1	—	4	12	4	5	10	12	12	5	15	8	88
North Westmorland	—	—	—	—	3	1	4	1	5	1	7	1	23

We still only have the services of a physiotherapist for two sessions weekly, but I am hoping that when the physiotherapist service i s further extended we shall have a considerable increase in the physiotherapy time at the chest centre. Bronchiectasis is a condition which, particularly in children, requires very frequent supervision by qualified staff. The average child requires supervision at least twice weekly and no more than two children can satisfactorily be supervised at the same time. With intelligent adults, treatment

should be supervised twice weekly for the first fortnight and thereafter they need only be supervised once each fortnight. This supervision is essential as postural coughing is a skilled measure and results from close consultation between the physiotherapist and the chest physician.

Asthma and Bronchitis

Large numbers of children continue to be seen suffering from asthma and bronchitis and full use is again being made of the physiotherapy facilities in their treatment. In contra-indication to the treatment of bronchiectasis, the same close supervision by the physiotherapist is not required here; children with asthma and bronchitis can best be treated successfully in classes of not more than 8 children after preliminary instruction of the child and parent at the commencement of treatment. These children should attend their classes once weekly and also continue to regularly carry out their breathing exercises at home.

Bearing in mind the essential difference in the treatment of bronchiectasis and chronic bronchitis and asthma, the accommodation required is also very different. At the chest centre here we are very handicapped so far as space is concerned, but use is made of a small room for the treatment of bronchiectasis; we really require a further room of about the same size, as, when the physiotherapy time at the chest centre is increased, other demands on this room will make it very difficult to fit in extra sessions. With regard, however, to the treatment of bronchitis where children can be treated satisfactorily in classes of not more than eight children this is more easily carried out in the rehabilitation department at the Cumberland Infirmary which has a big enough room for this purpose.

Many older people have also been seen and have been fully investigated. Chronic bronchitis can be quite incapacitating in adults; it is often associated with emphysema and the sum total is the considerable loss of much functional lung tissue entailing shortness of breath and interference with the individual's working capacity. Both in chronic bronchitis and bronchiectasis the individual is liable to acute inflammatory attacks and much can be done in impressing ordinary hygienic measures on these patients with a

view to preventing the acute respiratory infections which exacerbate their symptoms.

During the past 12 months much work has been done in various centres in the country on the bacteriology of these infections and on the value of the modern anti-biotics in their prevention. As far as treatment of the acute pulmonary infection is concerned both in chronic bronchitis and bronchiectasis, penicillin in adequate dosage, by injection, is probably our most valuable drug. In the prevention, however, of the acute respiratory infections which pre-dispose to the localised inflammation in the lungs, it would appear that an anti-biotic such as aureomycin is of some value when given in relatively small doses for a comparatively long period, but work on this subject is still going on.

Neoplasm

The number of cases of neoplasm seen and investigated during the year, although comparatively small, has necessitated considerable investigation.

As before, cases considered suitable for major surgery have been admitted to Shotley Bridge Hospital without any delay, and other cases have been referred to the radio-therapy department.

The death rate from cancer of all kinds abates very little and recent figures have shown a rise in overall cancer mortality in males by 6% and for women a fall of approximately the same amount. The resultant small disparity between the sexes is accounted for largely by the mortality from pulmonary cancer in males. Indeed, at one of the large general hospitals in London with 800 autopsies a year, pulmonary neoplasm accounts for 30% of all neoplasm examinations.

Much effort has been expended throughout the country to try and get early diagnosis in such cases, but, even where such an early diagnosis has been made on clinical and radiological grounds, there would appear to be much more important factors influencing the treatment of these cases. The growth rate of the tumour itself would appear to be of overwhelming importance. When first noted radiologically, even the size of the abnormality on the x-ray film is not a guide as some cancers, when first seen, may be slowly grow-

ing ones and others when first seen may be of the rapid invasive metastatic type. One is inclined to assume that cancer spreads generally by lymphatics but some investigators with equal evidence feel that there is some spread at one stage via the blood stream itself.

A recent investigation into gastric cancer even showed that the greater the delay and longer the symptoms the greater was the survival rate. It is well known that a patient with an untreated cancer of the breast may survive for a long period.

Our cases of lung cancer are so small that it would not be wise to draw any conclusions from them, but my own personal records, all of pulmonary neoplasms seen since 1934, and now numbering approximately 160 cases, show little difference in the survival rates between those who have been treated surgically and those who have been considered inoperable; even in such a small series as this, however, it is unfair to draw conclusions. Recent investigations elsewhere have suggested indeed that by the time a definite abnormality is noted radiologically most cases of pulmonary neoplasm have progressed too far to permit of successful surgery.

The recent publicity given to tobacco smoking and cancer both in the medical and lay press has prompted persons other than those suffering from neoplasm to ask "Should I give up smoking" a question which is not easy to answer. The evidence in support of a relationship between tobacco smoking and cancer is not in my view conclusive and in the absence of more definite evidence it would, I feel, be quite wrong for one to be dogmatic on this issue. I feel it is safe, however, to advise all young people to stop smoking, and this is probably good advice. In the case of smokers over the age of 40 I doubt very much whether any cessation of the habit would effect in any way the incidence of pulmonary neoplasm.

In spite of conflicting evidence which accumulates year by year we must in our present state of knowledge continue to make as early a diagnosis as possible.

Pneumoconiosis

Pneumoconiosis and Silicosis Panels are held at the chest centre in consultation with the Senior Permanent Member of the Silicosis Board. Most of the cases

naturally come from West Cumberland and most have been associated with the hematite industry. So far as East Cumberland is concerned a few cases come from the Alston area or from the Patterdale Valley in Westmorland.

I am well satisfied with the results of these panels; a considerable time is spent not only in the examination of the patient and his x-ray films but also in evaluating the percentage of disability due to the disease, that percentage, if any, due to some medical condition other than pneumoconiosis or silicosis.

Just as in tuberculosis the advice to a patient with pneumoconiosis varies with each individual case. Generally speaking, one would say that a stage 1 pneumoconiotic in young workers would prompt one to advise that they get out of the pit and seek fresh employment. In pneumoconiotic cases, stage 2 and 3 however, these would generally be permitted to stay in their employment providing they were working in "approved conditions" and remained under periodic clinical and radiological supervision.

It is a different matter in the more advanced cases of confluent massive fibrosis where there may even be cavitation. This confluent massive fibrosis is the result of infection being super-imposed on stage 2 and 3 pneumoconiosis and according to international classification they are classified either A, B, C and D depending chiefly on the size and extent of the confluent lesions. The infection may be either due to the tubercle bacillus or to some organism other than the tubercle bacillus.

The Cardiff school, who have had considerably more experience in this disease, feel that the infection is always tuberculous; this, even in spite of negative histological and bacteriological findings at autopsy. In Wales such patients are even allowed to continue with their employment in "approved" working conditions. and statistics there have shown that such patients, even those with cavities, live as long working underground as other patients with the same category of disease who have transferred to light industry outside the pit. Whilst these statistics are very convincing I would personally hesitate to advise a patient with massive fibrosis and cavitation to return to work underground.

Mass Radiography

Groups Examined (figures for 1952 given in brackets)

During 1953 the unit operated continuously throughout the Special Area and in addition to carrying out surveys at works and factories, surveys of the general public were carried out on 29 (24) occasions. One thousand four hundred and seven (2,033) contact cases were x-rayed, 1,079 from the East Cumberland area and 328 from West Cumberland. Six hundred and seventy-seven (938) National Service Recruits were examined; 4 were found to be suffering from active tuberculosis, 2 from bronchiectasis and 2 from heart disease.

Facilities for chest x-ray examination continued to be made available in our public surveys to school children of 14 years and over. The School Medical Officers of the authorities concerned were contacted and full advantage was taken of the service as 4,707 (4,642) children of these age groups passed through the unit. It is to be noted that examination of school children is only carried out after receiving the consent of the parents.

The full co-operation of the general practitioners in the areas visited was invited during each survey but unfortunately the number of persons referred by general practitioners declined from 355 in 1952 to 267 in 1953.

Sessions were held for members of the general public in 24 (20) towns and villages in the Special Area. Preliminary propaganda was carried out including advertisements in the press, in local cinemas and by posters and handbills. These public surveys necessitated no prior appointment and were well attended, 20,090 (23,281) persons having passed through the unit.

Results

During the year 41,532 (44,849) persons were examined by the unit. These included 1,069 (1,079) inmates of Dovenby Hall and Garlands Hospitals. Excluding the mental patients, 40,463 (43,770) civilians were examined, of whom 20,731 (22,816) were males and 19,732 (20,954) were females. These examinations are set out in the Ministry of Health age groups in Table 1.

TABLE 1 M.M.R.

Age	14 & Under	15-24	25-34	35-44	45 49	60 & Over.	Total all ages.
Male	1,715 (1,834)	4,715 (5,289)	5,039 (5,156)	3,876 (4,407)	4,200 (4,860)	1,186 (1,270)	20,731 (22,816)
Female ...	1,648 (1,893)	7,196 (6,867)	4,072 (4,180)	2,995 (3,545)	3,065 (3,617)	756 (852)	19,732 (20,954)
Totals ...	3,363 (3,727)	11,911 (12,156)	9,111 (9,336)	6,871 (7,952)	7,265 (8,477)	1,942 (2,122)	40,463 (43,770)

Number recalled for full sized X-ray film—1,832—4.41% of total examined (1,665—3.71%)
Number referred for clinical examination—593—1.43% of total examined (600—1.34%)
Number failing to attend for full sized film—104—5.68% of those recalled (93—5.58%)

The detailed results of the x-ray examinations are shown in Table 2.

TABLE 2

	Male.	Female.	Total.	Percentage of total examined.
Abnormalities revealed.				
(i) Non-tuberculous conditions:				
1. Abnormalities of ribs, ...	170	187	357 (422)	.86 (.94)
2. Bronchitis & Emphysema	426	552	978 (713)	2.11 (1.59)
3. Bronchiectasis	62	31	93 (94)	.22 (.21)
4. Pneumoconiosis	90	—	90 (130)	.22 (.29)
5. Pleural thickening	274	105	379 (358)	.91 (.80)
6. Intrathoracic neoplasms ...	7	2	9 (11)	.02 (.02)
7. Cardiovascular lesions—				
(a) Congenital	2	1	3 (2)	.007(.004)
(b) Acquired	134	201	335 (390)	.81 (.87)
8. Miscellaneous	102	71	173 (163)	.42 (.36)
(ii) Suspected Pulmonary Tuberculosis. Previously known—				
1. Active	4	9	13 (20)	.03 (.04)
2. Inactive	8	9	17 (19)	.04 (.04)
Newly discovered—				
1. Active	59	62	121 (131)	.29 (.29)
2. Inactive primary	249	167	416 (458)	1.00 (1.02)
3. Inactive post-primary ..	244	170	414 (658)	1.00 (1.47)

The number recalled for clinical examination included all persons presenting radiological evidence of possible active pulmonary tuberculosis, cases of bronchiectasis, particularly those in the under 35 age groups,

all neoplasms and many of the persons presenting iron ore and pneumoconiotic changes in the x-ray pictures. Clinical examinations were carried out at the chest centres.

Table 3 gives a detailed analysis of the work of the unit divided into the East and West Cumberland areas.

Table 3.

EAST CUMBERLAND									Source of examination.	WEST CUMBERLAND								
Miniature Films.	Large Films.	Clinical Exams.	Active T.B.	Inactive T.B.	Bronchiectasis.	Neoplasms.	Pneumoconiosis.	Cardiac Conditions		Miniature Films.	Large Films.	Clinical Exams	Active T.B.	Inactive T.B.	Bronchiectasis.	Neoplasms.	Pneumoconiosis.	Cardiac Conditions
177	42	20	2	4	5	—	—	4	Doctors' cases ...	90	16	3	2	9	—	—	1	2
10	—	—	—	—	—	—	—	1	Ante-natal cases ...	2	—	—	—	—	—	—	—	—
1079	39	17	—	28	—	—	—	8	Contact cases ...	328	24	6	2	20	—	—	3	1
667	40	17	4	9	2	—	—	2	National Service Recruits	—	—	—	—	—	—	—	—	—
3015	65	15	2	19	4	—	—	2	Scholars	1692	35	14	6	21	1	—	—	3
202	14	—	—	4	—	—	—	—	School Staff	—	—	—	—	—	—	—	—	—
12788	640	200	30	256	37	4	6	138	General Public ...	7302	347	134	41	175	21	3	73	67
7443	314	83	10	152	14	1	—	64	Surveys	5668	194	60	23	112	5	1	7	21
791	48	24	8	34	2	—	—	24	Mentally defective patients	278	14	—	4	4	2	—	—	1
26172	1202	376	56	506	64	5	6	243	TOTAL	15360	630	217	78	341	29	4	84	95

All cases of pulmonary tuberculosis, bronchiectasis, pulmonary neoplasm and pneumoconiosis which were found were further investigated at the chest centres and treatment where practicable was started immediately.

Many other abnormal conditions were discovered, some meriting considerable investigation, and occasionally necessitating a short period in hospital. Those requiring treatment were referred to the appropriate medical or surgical department.

Comments

The number of persons passing through our unit has declined during 1953, the result chiefly of our policy in examining smaller communities in the area who had not previously been examined. Mass radiography will continue to play a vital part in the war against tuberculosis and the very nature of this struggle will inevitably entail a smaller number of persons examined annually because it will increasingly be made available to certain smaller groups of the population selected chiefly by their exposure to infection. You will recall that the statistical data for 1951 and 1952 suggested that there was a larger incidence of active tuberculous disease in certain parts of the West Cumberland area. This would appear to be borne out by the 1953 figures. As a result of this, in the spring of last year we had arranged to devote an increasing part of the time to survey work in West Cumberland but the full effects of this will not be known until the figures for the current (1954) year appear.

1954 will also see a considerable increase of the scheme for B.C.G. vaccination; namely in its extension to school children between 13 and 14 years of age. I hope that the co-operation already existing between the local health authorities and ourselves will permit of mass radiography examination being made available to all those children at about the same time as their Mantoux testing is done. It might and should be possible for all the family contacts of the Mantoux positive reactors to pass through the unit at a following mass radiography session.

Once again I would emphasise that the results of the Mass Radiography Service cannot be assessed on

the number of abnormalities found and especially on the number of new cases of active tuberculosis discovered. Important though these figures are, it is not less important to be able to give an assurance that so large a proportion of the general public have normal chest x-rays.

Again even in spite of a normal x-ray report, should chest symptoms develop later, the person concerned should seek further medical advice, preferably from his own doctor.

I would, however, plead for a bigger response from factory workers when our unit is doing a factory survey. The unit can and will cope just as easily if 100% of the factory staff pass through as with 50 or 60%.

Acknowledgements

Once again it is a pleasure to acknowledge the valuable help received in the chest centre work as a whole from the staff of the Public Health Department, and particularly I would express my sincere thanks to Dr. Kenneth Fraser, the County Medical Officer, for his continued valuable co-operation.

WEST CUMBERLAND

(Dr. R. Hambridge, Consultant Chest Physician)

Chest Clinic Organisation

For the first nine months of 1953 there was no variation in arrangements reported in the previous year. Outpatient work continued at the county health service premises at Millom, Egremont and Whitehaven and in temporary accommodation for the main work at Workington Infirmary. At the beginning of the last quarter of 1953, the new chest clinic in Workington Infirmary grounds became available and since early October this much more commodious and conveniently designed building has allowed much needed extensions in routine work to be more efficiently pursued.

Proper premises have, for the first time, provided adequate space for the voluminous clerical requirements of a chest clinic: full x-ray facilities in the clinic have expedited the physicians' work; and the chest service is no longer dependent upon the sessional availability of ad hoc premises used for other purposes with consequent restrictions on time and personnel.

The Workington Chest Clinic is a substantial and tangible evidence of the interest held by the Group Management Committee in furthering the community's welfare: their bounty will undoubtedly leave its mark in improving the efficiency of the chest service.

Details of the clinic attendances, which follow, show a considerable increase over those for 1952: not all is attributable to the change in premises at Workington, however, as this change was effected late in the year and by far the greater proportion of the work was conducted under circumstances of considerable inconvenience and difficulty.

Concurrently with the opening of the Workington Chest Clinic, Dr. M. S. Hicks, Assistant Chest Physician took up office and has undertaken responsibility for the Whitehaven Clinical area as well as part of Workington's requirements: the refill clinic, details of which are given later, has been split into two sessions of manageable proportions, each in the charge of one physician.

Tuberculosis Notifications

The total of fresh notified cases for 1953 is 246, showing an advance over 1952 of 10 cases. The number of fresh cases diagnosed, however, totalled 281, showing

an advance over 1952 figures of 45 cases. Part of this advance is unreal owing to the time lag in notification of some cases diagnosed during 1952. Allowing for this, there does not appear to be any very significant change recently in the current case rate: however from the following table it is evident that a definite change in the rate of diagnosis—and probably the mode of diagnosis—occurred from 1949 onward. These figures will later be related to the mortality rate in graph form.

TABLE I

Year	...	1943	1944	1945	1946	1947	1948	1949	1950	1951	1952	1953
Population	...	125040	120940	119210	122950	124210	129670	131350	134140	133043	132560	133670
New Notifications	...	192	181	210	179	169	203	187	218	243	236	281
Case Rate/1000	...	1.5	1.5	1.8	1.4	1.5	1.5	1.4	1.6	1.8	1.8	2.1
No. Deaths	...	93	94	118	88	102	96	86	90	73	40	40
Death Rate/1000	...	0.74	0.78	0.99	0.71	0.81	0.74	0.65	0 67	0.54	0.30	0.29

Posthumous Notifications

One such notification occurred during the year compared with 6 in 1952. Both these numbers are small enough for the variation to be due to chance. The proportion of posthumous notifications is 1 : 40—a gratifyingly low figure: when viewed against the background of a total 246 notifications, it certainly does not suggest a significant rate of failure of notification (.4%).

Age Group Incidence of Fresh Notifications

The graph below shows the number of fresh notified cases according to 5 yr. age groups from new born to 75 yrs. of age. The graph is not a true indication of the incidence of tuberculosis in the West Cumbrian community: it shows, however, certain significant features.

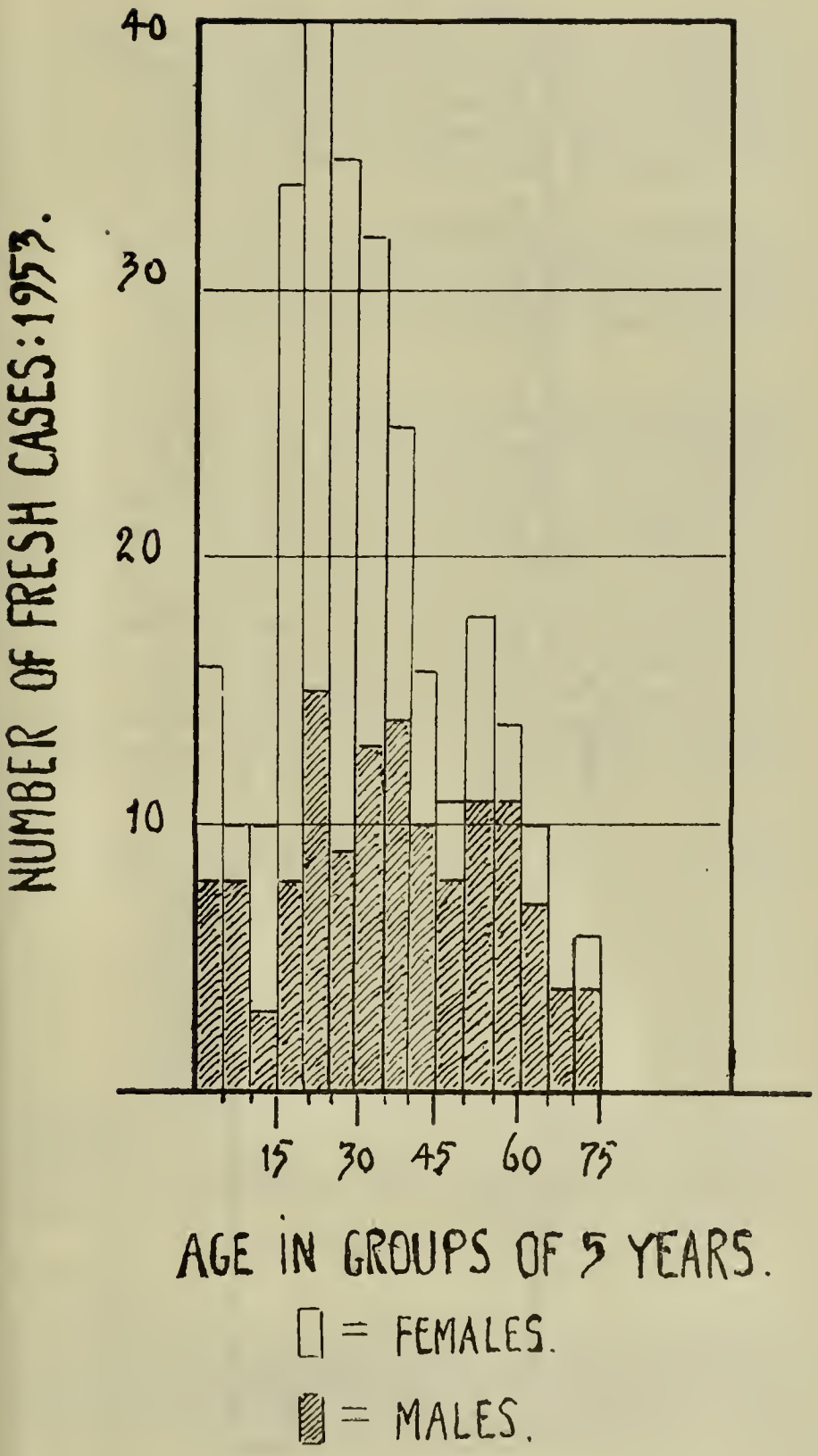

NUMBER OF FRESH CASES: 1953.
40
30
20
10
15
30
45
60
75
AGE IN GROUPS OF 5 YEARS.
= FEMALES.
= MALES.

TABLE II

	0-4.	5-9.	10-14.	15-19.	20-24.	25-29.	30-34.	35-39.	40-44.	45-49.	50-54.	55-59.	60-64.	65-69.	69-74.	Totals.
Males ...	8	8	3	8	15	9	13	14	10	8	11	11	7	4	4	133
Females ...	8	2	7	26	25	26	19	11	6	3	7	3	3	0	2	148
Total ...	16	10	10	34	40	35	32	25	16	11	18	14	10	4	6	281

(a) Although the numbers of males and females are similar, the proportion of young women is much higher than of young men: and the continuance of active disease is higher in males of more advanced years than in women.

(b) The relatively high proportion of notifications in children (under 15), particularly 0-4 year age group suggests an undesirable amount of unrecognised or uncontrolled disease in parents or family circles.

This young age group has been separately studied in order to trace the probable source of infection: contact examinations are incomplete, owing to default, delay or frank opposition on the part of parents to whom examination has been offered, and in nine of the group of 34 are so incomplete as to have been valueless. Nevertheless of the 34, 33 additional infectious cases have been identified, 17 of them previously known and 16 not previously suspected. It is significant that in 15 instances the potential source case was one or other parent: and 5 cases were close relatives not in the immediate family circle, but with whom frequent contact occurred.

This group of children notified is made up of the following disease states :

Tuberculous meningitis	15
Glandular tuberculosis	14
Tuberculous peritonitis	2
Tuberculous pericarditis	1
Miliary tuberculosis	1
Skin tuberculosis	1

many of which have long been regarded as predominantly of bovine origin: but as has been stated, arose in circumstances most suggestive of a human source.

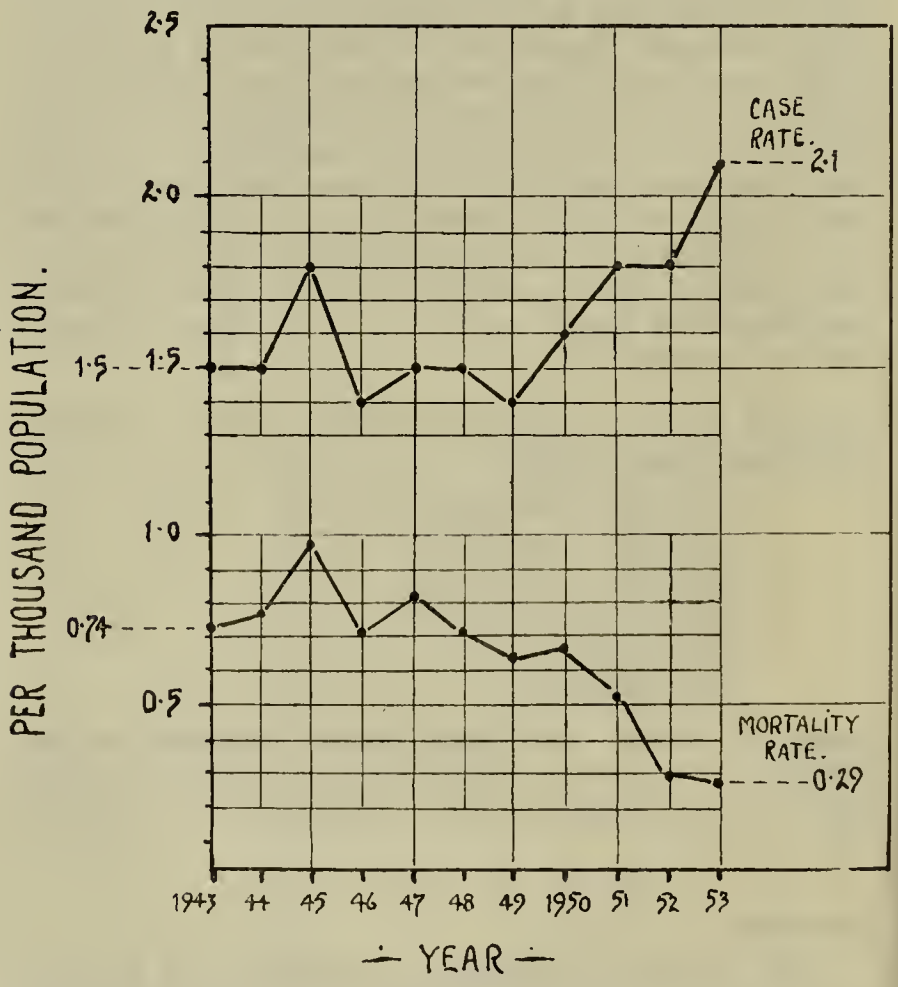
Death Rate

The recorded death rate for 1953 for all forms of tuberculosis for 1,000 population was 0.29: this figure is not appreciably lower than that for 1952 (0.30) and is still well above the National average figure.

The total recorded deaths, however, is small (40) as in the total population; annual statistical variations are more likely to appear in these circumstances, until a much more firm measure of control of the disease is established.

The proportion of tuberculosis deaths in the Special Area occurring in West Cumberland is again lower, being now 63% against 70% for 1952 and 80% in 1951 and 80% in 1950.

The combined graph showing the rates for fresh cases annually, and deaths from all forms for corresponding years, displays clearly the changing circumstances of tuberculosis control in this area.



Prior to 1949 there was a close parallelism between the rate at which cases were diagnosed and mortality. The trends are indeed so similar that it is probable

tuberculosis was not diagnosed in a large proportion of cases until disease was very far advanced.

Since that date there has been a progressive enlargement of facilities both for diagnosis—additional x-ray plant and extension of its use to general practitioners' requests: introduction of Mass X-ray programmes; an increase in consultant services in all branches of medicine—and for treatment, both institutional and domiciliary. The current trend may be interpreted as evidence that the more cases are identified the fewer the deaths.

The falling off in the steep decline in mortality rate during 1953 should not be given a false significance: factors influencing this have been mentioned already: while it should be borne in mind that some years must necessarily elapse before those many cases now known, of advanced years and with untreatable disease, no longer contribute to this figure.

Tuberculosis Register

During the year 281 fresh cases were added to the register which at the 31st December totalled 1,219 cases, compared with 996 on the previous 1st January. The number of known cases per 1,000 population is 9.04, compared with 7.53 twelve months ago.

Contact Examinations

Although the number of routine contact examinations made during 1953 is considerably in advance of 1952, this essential function of the Chest Service remained incomplete at the end of the year. As has been mentioned, adequate premises became available only in the last quarter of 1953 and the need for additional medical staffing was especially noticeable in the growing list of contacts requiring examination and for whom appointments could not be found. Nevertheless 1,245 contacts were examined, compared with 249 for 1952: and in addition, more remote contacts in older age groups or those who could not give time from work to attend for clinical examination and x-ray were referred to the Mass X-ray Unit when functioning in their residential area. A further 529 were dealt with in this way: which is better than no examination of any kind but is by no means as satisfactory or conclusive as a routine clinical attendance with orthodox radiography.

The ratio of contacts examined to new cases diagnosed during the year is 1,245: 281 or approximately 4:1. Owing to the back log of contacts not called for examination in previous years however, the ratio is not a fair statement of contacts seen related to fresh cases diagnosed. An accurate figure for this ratio is not obtainable, but it is likely that some 594 contacts of the 281 fresh cases were seen at the clinics and a further 258 were examined by Mass X-ray giving an approximate ratio of (832:281), or 3 contacts to 1 index case.

For the purposes of contact examination, posthumous notifications have been treated as index cases: no other action has been taken by the Chest Physicians.

B.C.G. Vaccination

This routine procedure has continued at chest clinics during the year: and with improved clinic facilities in the last quarter of 1953 making additional sessions possible, a larger number of contacts seen has resulted in an increase of vaccinations.

Comparative figures for recent years are :—

Number of persons vaccinated during 1950 and 1951	60
Number of persons vaccinated during 1952 ...	87
Number of persons vaccinated during 1953 ...	224

Vaccination has been offered every susceptible identified, and in only very few cases has the offer been rejected. As mentioned in the report for 1952 the rate at which B.C.G. can be given to this limited group is unlikely to exert any noticeable effect on morbidity figures, and the recent proposal to extend the scheme to include all children prior to leaving school, on a voluntary basis, is a most welcome step towards controlling disease arising from early adolescent primary infection.

Although no statistical date exists to identify the age groups in West Cumberland at which primary infection is maximal, it is probable that at age 13 relatively few children will be found uninfected and therefore capable of deriving benefit from B.C.G.: and it is likely that a much earlier age group will require attention for mass voluntary vaccination to effect morbidity appreciably.

As contingent evidence supporting this view the following considerations are quoted :

1. A total of 36 cases of active disease was notified for the age groups 0-14 years inclusive during the year: in the 15-19 years group, i.e., that most likely to benefit by B.C.G. at 13, 34 cases were notified. If undiagnosed deaths be any indication of degree of control, it is significant that 3 such deaths occurred before age 14 and none in the remaining notifications until the age 39 group, the inference being that there is much unrecognised infection in children.

2. The extent of the hazard to which contacts are exposed in the home can be roughly estimated from an environmental study of 176 consecutive fresh cases during 1953.

Of this number of cases there were 171 child contacts, living in the same household as the index cases: 54% of cases shared a bedroom and 45% were sharing a bed at the time of diagnosis.

3. Although 281 fresh cases were added to the register during the year, only 242 contacts were found to whom B.C.G. was given: and these were in a large proportion in the more remote or intermittent contact categories.

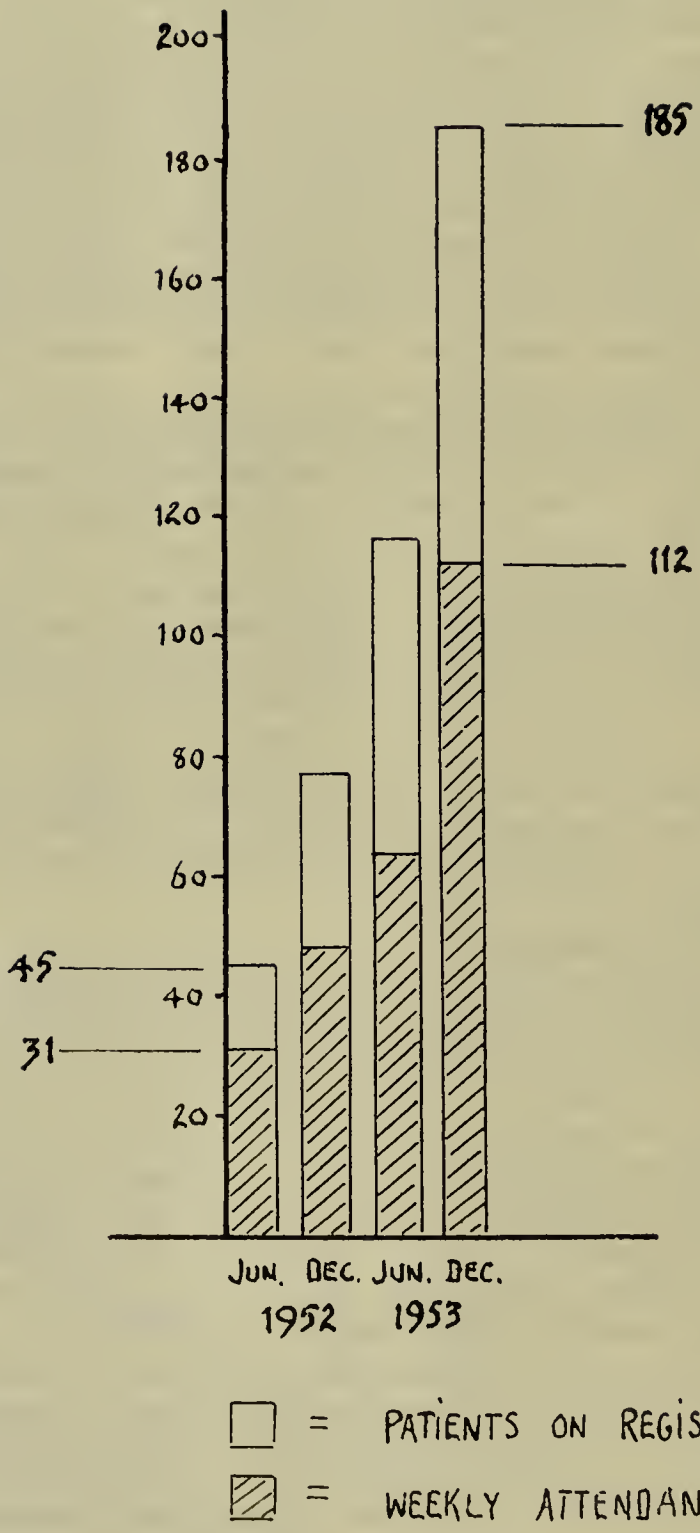
Chest Clinic Attendances, etc.

A very noticeable increase in attendances occurred during the year at all clinics: the totals for West Cumberland in the past three years are :

1951		1952		1953
2,847	...	3,876	...	7,593

Total attendance figures are subject to many intangible influences. The refill clinic thus makes up 3,613 attendances of the total figure: every effort is made to keep this figure as low as possible commensurate with individual patients' needs.

The increase in the number of patients treated during the year by collapse therapy has again enlarged the size of the refill clinic register and consequently the attendances. Graph 3 shows the considerable rise in both, which has necessitated an additional session weekly.


200
180
160
140
120
100
80
60
45
40
31
20
185
112
JUN. DEC. JUN. DEC.
1952 1953
= PATIENTS ON REGISTER.
= WEEKLY ATTENDANCES.

The refill register has risen from 78 patients at December, 1952, to 185 patients at December, 1953, and average weekly attendances from 48 to 112.

The average attendance per session for all chest clinics in this area again rose during the year :

1951	10
1952	15
1953	27

By far the largest proportion of attendance was at Workington Infirmary which handled all the refill clinics and much of the contact work during the year. Excluding the refill clinics, attendances at the four centres were as follows :

Millom	253
Egremont	826
Whitehaven	1,027
Workington	1,874

No separate tally of patients attending and needing transport has been kept: but with an extensive programme of domiciliary treatment established, in which the general practitioners take an active and responsible part, any apparently startling increase in calls on the transport service must be read in conjunction with the growth of the chest service: and the policy of maintaining peripheral clinics, with their attendant problems of administration, can be seen from the separate clinic attendance figures to have relieved the patients of a very considerable amount of travelling over areas ranging up to 40 miles or more, and to have avoided much consequent transport mileage.

Treatment

During the year, additional beds for the treatment of adults were made available at Blencathra Sanatorium, Galemire Infectious Diseases Hospital and Ellerbeck Hospital. At the last named considerable improvements were in train at the close of the year to make more effective use of the wards previously occupied by pre-convalescents from the general medical and surgical wards at Workington Infirmary: these wards have been allocated by the Hospital Management Com-

mittee to the chest service to offset the loss of the proposed Camerton project and have already proved of great assistance in both reducing the waiting lists and making more effective treatment immediately available. Facilities for fluoroscopy are planned and should be installed in suitable quarters early in 1954.

Data relevant to centres for treatment follows :—

Blencathra: The allocation of beds for West Cumberland varied during the year according to need: at the end of 1953 the figures were:

Male	30
Female	39

to which there were admitted a total of 125 patients.

Ellerbeck: The 7 female beds remained during the year and in the first quarter 8 male beds were provided by converting the block no longer required for resident staff. To these 24 male and 23 female admissions were made.

Galemire: Twelve unused infectious disease beds in the new hut were made available for adults: and cubicle accommodation for children in the main building was used from time to time. To these beds, 16 males, 13 females and 2 children were admitted

Total admissions locally for 1953 numbered 78 compared with 49 in 1952 and 16 in 1951: with those admitted to Blencathra a total of 203 patients were admitted to the main centres during the year.

Small numbers of patients have, from time to time, also been admitted to Meathop, Wooley and Poole Sanatoria. The lack of any proper provision for long term illness in children of school age locally has been largely offset by the excellent facilities at Poole.

Infants, mainly suffering from tuberculous meningitis, miliary tuberculosis and other forms related to immediate post primary diseases have been treated by the consultant physicians in the paediatric wards at Workington and Whitehaven, where resident medical staffing is available: without this invaluable assistance,

the mortality rate in this area would certainly have been appreciably higher, as no fewer than 14 cases of T.B. meningitis alone were notified during 1953.

Surgical Beds

With the opening of Seaham Hall at which centre 3 male and 3 female beds were allocated to West Cumberland, the absolute lack of co-ordinated thoracic surgery for tuberculosis which previously prevailed has been relieved. By the end of 1953, eight patients had been admitted to Seaham Hall, seven to Poole Sanatorium and two to Shotley Bridge, totalling 17. The waiting list of patients requiring thoracic surgery and in a state suitable for operation is now very small.

Failures of Admissions and Irregular Discharges

A disturbingly high proportion of patients with active disease requiring treatment under conditions of segregation either refused admission, even under very strong persuasion, or took their own discharge. Behaviour problems of this kind are in a large number of cases strictly related to unsatisfactory environment or unresolved social and domestic problems. The figures set out hereunder show the order of this problem for this area and indicate a weakness in tuberculosis control which no amount of medical skill is likely to surmount.

(a) Refused residential treatment completely ...	37
(b) Refused more remote residential treatment but accepted admission nearer home ...	50
(c) Irregular discharge	
1. Disciplinary dismissal	Nil
2. Own discharge	19

All cases have been investigated and the reasons given for irregular action vary with the individuals concerned: the problems are mainly human, but there is no doubt an easier air of optimism has been engendered in many by the more hopeful reports on the problem of tuberculosis seen and heard frequently in the lay press. Such a by-product of partial success is a mixed blessing: there is no doubt that from amongst the group under consideration a relatively high proportion will contribute to mortality rates in subsequent years.

Case Finding Measures

No specific programmes of case finding were introduced during the year. The established procedures of referral from general practitioners and hospital staff, contact search and Mass X-ray are the only means so far adopted in this area. Tuberculin testing of selected age groups, routine ante-natal chest x-ray or routine radiography of certain groups known to contain a higher morbidity are not practised on an organised scale. It is hoped that the introduction of such measures will not be unduly delayed. Facilities for X-ray are very good in West Cumberland and if these can be linked to established chest clinic procedure, ultimately a reduction in the amount of disease in this area should result. A programme of selective tuberculin testing is envisaged for the latter part of 1954.

Mass X-ray Unit Activities

The one mobile unit shared with the remainder of the special area has continued to operate during the year and a summary of its work is set out below :

Table III
WEST CUMBERLAND

Source of Examination.	Miniature films.	Large films.	Clinical Exams.	Active T.B.	Inactive T.B.	Bronchiectasis.	Neoplasms.	Pneumoconiosis.	Cardiac Conds.
Doctors' Cases	90	16	3	2	9	—	—	1	2
Ante-natal Cases	2	—	—	—	—	—	—	—	—
Contact Cases	328	24	2	2	20	—	—	3	1
National Service Recruits	—	—	—	—	—	—	—	—	—
Scholars	1692	35	14	6	21	1	—	—	3
School Staff	—	—	—	—	—	—	—	—	—
General Public	7302	347	134	41	175	21	3	73	67
Surveys	5668	194	60	23	112	5	1	7	21
Mentally defective patients	278	14	—	4	4	2	—	—	1
TOTAL	15360	630	217	78	341	29	4	84	95
	*15628	620	240	80	423	26	2	117	148

*1952 figures

From this table the rate of disclosure of active tuberculosis is shown to be 5.1 cases per thousand: the comparative figure for East Cumberland is 2.1 cases per 1,000. It may be noted that the fifteen thousand micro films taken constitutes 37% of the total taken by the unit during the year and produced a yield of 58% total fresh active cases of tuberculosis in the Special Area.

These findings are likely to influence the unit's operating programme for 1954.

The Welfare Services

I am indebted to the County Welfare Officer (Mr. Walker) for the following report on the Welfare Services, the administration of which is in the hands of the Welfare Sub-Committee of the Health Committee.

National Assistance Act, 1948

This supplement, for the year ended 31st March, 1954, must be shorter than usual, in that, apart from reiterating what has been said in previous reports regarding the consolidation and advancement of welfare services as administered by the County Council under the above Act, and again referring to the further efforts introduced to stimulate and extend voluntary services in the desire to mitigate the sense of loneliness and sometimes frustration often felt by elderly people living in their own homes, one can add little to the points of principle previously expounded and dealt with in considerable detail.

One of the fundamental objects of the Act was to achieve the final and complete break-up of the Poor Law and the creation of entirely new services founded on modern conceptions of social welfare, and whilst it can only be by the passage of time that such an end can be accomplished, the County Council is slowly but surely shaping and adjusting its administrative machinery to achieve that desirable end in the none too distant future.

Whilst in the field of domiciliary and other services of a non-residential nature, there are difficulties (which at times appear almost unsurmountable) in implementing new ideas of social betterment for the aged and handicapped, one urgent need is that of providing more residential accommodation of the modern type for aged persons in need of care and attention not otherwise available to them, whilst at the same time doing everything possible via housing authorities and voluntary bodies to make it possible for elderly people to remain in their own homes for as long as possible. On the latter issue, and ever careful of avoiding the danger of falling into the fallacy that people of pensionable age are both infirm and helpless, extended efforts are being made to seek the co-operation of housing authorities in providing small dwellings of the bungalow type, and/or, where possible and justified, flats (either newly erected or in large type houses suitable for adaptation as such) operated jointly by the Housing Authority and the W.V.S., or other voluntary bodies such as Old People's Welfare Committees. These measures would not only release two and three-bedroom type houses for family occupation, but would

in themselves be a direct and effective way of helping elderly people to live a normal life for as long as possible, with the maximum amount of happiness and the minimum amount of expense.

So far as the County Council is concerned in the provision of Part III residential accommodation, it has already been indicated that in addition to the retention of certain accommodation at two country type former Public Assistance institutions for those elderly people who would not be considered suitable for, or fit into hostel life, something like thirteen homes or hostels (including a holiday home) would be required to give complete cover on a long-term policy. In addition to one modern hostel already in commission and two other mansions at present in course of adaptation for use as hostels, negotiations are at present proceeding for the purchase of premises near to Millom, which, with slight alterations, would provide the necessary accommodation for that area (i.e., the southern part of the administrative county).

Arising out of subsidence which has had the most unfortunate effect of causing the closure (at least temporary) of the hospital block of some ninety beds, at Meadow View House, Whitehaven (a joint user institution providing, in addition to beds for the chronic sick, accommodation for some two hundred Part III residents) the Welfare Committee is to be urged to consider the immediate extension of the policy of providing small modern hostels, in that such an extended policy would not only be in keeping with the spirit of the National Assistance Act, 1948, but would secure economies in maintenance and administrative costs, and bring to an end the barrack-like or institutional atmosphere associated with such premises as Meadow View House which was erected over a hundred years ago. However up-graded in amenities and facilities, such old and rambling buildings, in addition to being expensive to maintain and uneconomical to run, can never take a place in the modern planning of residential accommodation for the future. Furthermore, it is considered that when the modern type of residential accommodation becomes more freely available, there will be a greater demand for it from those classes of elderly persons who are at present deterred by the institutional association of establishments such as

Meadow View House. Whilst on the subject of economy in administrative and running costs, it can be said from experience in this County that the "standard charge" as ascertained for the running of a small modern residential hostel has, so far, proved to be considerably less than that which applies in the case of the large type joint user institution at Whitehaven.

Present Part III. Accommodation and Hospital Facilities for Chronic Sick

Part III Residential Accommodation is at present provided in three establishments (attached to which are small hospitals or sick ward blocks catering in the main for the chronic sick, together with a small maternity unit of three beds and three cots at Meadow View House, Whitehaven) and one modern hostel. The establishments are:—

No	Establishment	Number of Beds. Part III. Accommodation Males	Females	Total		Hospital Males	Females	Total
1.	Station View House, Penrith	27	15	42	..	16	16	32
2.	Highfield House, Wigton	50	19	69	...	17	18	35
3.	Meadow View House, Whitehaven ...	147	67	214	...	42	50*	92*
4.	Grange Bank, Wigton	—	19	19	...	—	—	—
		224	120	344	...	75	84	159

*Includes small maternity ward of 3 beds and 3 cots.

As the predominant user of the first three establishments prior to 5th July, 1948, was for other than hospital purposes, they remain wholly vested in the County Council.

Pursuant to the provisions of Paragraph 7 (1) of the 6th Schedule to the National Assistance Act, 1948, arrangements were entered into with the Regional Hospital Board whereby, until the Minister of Health otherwise determines, the beds in the hospital sections of the first three establishments, to the total number of 159 (see details above) are reserved to the Board for the maintenance and treatment of persons for whom the Board became responsible as from 5th July, 1948.

Under the Council's (Provision of Accommodation) Scheme, 1949, the modernisation and improvement of the Part III accommodation listed above, and of the amenities and services therein provided, have proceeded on normal lines during the year. With the exception of Highfield House, Wigton, where improvements were brought to a temporary stand-still due to major alterations being carried out in the Hospital (necessitating the temporary use of other buildings for the nursing of a reduced number of sick patients) and where Part III accommodation was fully occupied, it is considered that all necessary major improvements and upgrading such as the structure and lay-out of the other former institutions would permit, has been practically completed.

Whilst outside the actual period covered by this report, one feels bound to make reference to the most unfortunate position which has arisen at Meadow View House, Whitehaven, where, due to recent subsidence (June, 1954), the hospital block had to be evacuated and the sick patients transferred elsewhere. For the present, and until the future position is resolved, there can be no further admission of sick patients to the hospital. An early meeting is to be sought with representatives of the Ministry of Health and the Hospital Board and its associated Committees to review the whole position, and decide as to the future use of the hospital. It would be a calamity for the West Cumberland Area if this Chronic Sick Hospital had to permanently go out of commission, with no other provision in the area as a substitute.

The following table shows the number of admissions and discharges during the twelve months to the 31st March, 1954:—

	Station View House, Penrith			Highfield House, Wigton.			Meadow View House, Whitehaven.			Grange Bank, Wigton.	
	Part III	Hosp.	Total.	Part III	Hosp.	Total.	Part III.	Hosp.	Total.	Part. III.	Total.
Admissions	20	36	56	35	42	77	144	190*	334	15	15
Discharges	25	16	41	51	20	71	142	106	248	13	13
Deaths	—	22	22	—	29	29	2	86	88	—	—
Residents and Patients maintained on 31/3/54	30	27	57	45	19	64	123	77	200	17	17

*Included in this figure are 23 births.

Charges for Accommodation

In accordance with the provisions of Section 22 (2) of the Act, the County Council increased the standard charge from 63s. per week to 87s. 6d. per week as from 1st October, 1953, in respect of Part III accommodation provided at the first three named establishments, and a rate of 70s. per week for application to the Grange Bank modern hostel. The rates will remain in force until reviewed by the Committee after considering the costing statement for the financial year ended 31st March, 1954. During the year ended 31st March, 1954, and with the exception of 34 residents who have paid for their accommodation, etc., at rates between the minimum charge (see note below) and the standard charge, the remainder have made payments at the minimum charge, the total payments by residents during the year amounting to £14,555. In a few cases only did the respective Area House Committees find it necessary to write off small outstanding amounts as irrecoverable.

[N.B.—Under the National Assistance (Charges for Accommodation) (Amendment) Regulations, 1953, the minimum charge was increased from 21s. to 26s. p.w. as from the 3rd August, 1953.]

Monetary recompense to residents rendering assistance

Residents who voluntarily give a substantial measure of regular assistance in the running and maintenance of Part III accommodation, continue to have their accommodation charges waived up to a maximum of 10s. 6d. per week for such period as the House Committee may decide. The anomalous position that payments cannot be waived under Section 23 (3) of the Act in respect of services rendered in the hospital section, still remains, and any payment made by a Hospital Management Committee to Part III residents giving such services, must be taken into account in assessing the resident's ability to pay for his or her Part III accommodation.

At the end of March, 1954, there were 36 males and 20 females receiving remissions of 2s. 6d. or 5s. per week, having regard to the measure of regular assistance given. The total remissions or reduction in collections amounted to £10 12s. 6d. per week, or at the rate of approximately £552 per annum. The position

in each case is reviewed monthly by the Area House Committees, when consideration is also given to new or other cases qualifying for inclusion within the arrangement.

Medical Attention

General medical supervision of the Part III accommodation is undertaken by the former Medical Officers, who are also responsible for the treatment of patients in the accommodation reserved to the Regional Hospital Board.

Residents have the right to select their own doctor, and the matter of the capitation fee payable to the doctor lies between himself and the Executive Council appointed under the National Health Service Act, 1946. Chiropody services have been provided free of cost to the residents, who derive much benefit therefrom.

Holidays

Under the amenity provisions of the Act the County Council have, over the past four years, authorised a week's holiday at the seaside, or other approved place, for aged residents in Part III accommodation. This holiday is arranged in the early part of the season, advantage being taken of specially reduced boarding rates offered to local authorities arranging holidays for old people. The holiday, whilst being of great benefit from a health point of view, is greatly appreciated by the old people.

Residential Accommodation Provided by Voluntary Organisations

The arrangement with the Carlisle Diocesan Council for Social and Moral Welfare, whereby residential or temporary accommodation is made available at Coledale Hall, Carlisle, for a like purpose as that provided by the County Council under the Part III provisions of the Act, continues to operate, and is of considerable value to the County Council. Appropriate grants are made to the Diocesan Council and the arrangement is reviewed each year on the basis of records of county cases received into Coledale Hall.

Temporary Accommodation

Although at the moment this type of accommodation can be provided only in the former Public Assistance Institutions, not as yet adapted in whole or in

part for families to live together as units, no serious difficulties have been experienced in providing the accommodation, although the loose and "couldn't care less" attitude of mothers in the matter of parental responsibilities to their children is still very much in evidence.

During the year ended 31st March, 1954, 38 cases (representing 32 men, 12 women and 20 children) were provided with temporary accommodation due to eviction from houses or rooms, or inability to find suitable lodgings, the highest number maintained in any one week being 19 persons (13 men, 2 women and 4 children). The 38 cases consisted of 9 family units. On the 31st March, 1954, temporary accommodation was being provided for 2 men, 3 women and 9 children.

An arrangement (which it is hoped will be adopted in other areas) has been effected with one Housing Authority whereby an indication is given to the District Welfare Officer of any case where eviction appears to be on the threshold of certainty. The defaulting tenant is then interviewed, advised of the consequences which might follow eviction, and as to the nature, extent and cost of temporary accommodation, which could only be provided by the County Council at one of their former institutions. This arrangement has had the effect of some defaulting tenants seeing the error of their ways, and the staying of eviction proceedings. Additionally, it is a great advantage to the County Council in that the maintenance of one person in Part III temporary accommodation costs, on an average, £4 7s. 6d. per week.

Old People's Welfare—Voluntary Effort

It is a matter of regret to record that the efforts of the Cumberland Old People's Welfare Committee to further develop voluntary interest through the agency of local Welfare Committees are not meeting with the success one had hoped. In the period under review only two additional local committees (Alston and Nenthead) have been formed—making four local committees affiliated to the county committee. Some of the reasons attributable to this slow expansion and development of voluntary effort were given in last year's report, and at the moment all one can say is that every support is being given to the county committee in the furtherance of efforts directed to secure

the well-being of elderly people living in their own homes.

Negotiations are being opened up with the Women's Voluntary Services for an extension of the Meals on Wheels Service, which is only applied at the moment to a very limited extent in Penrith. One does express the hope that this service, which is of great value to elderly people living in their own homes, will be extended in the near future to many other areas throughout the administrative county.

At a recent conference of representatives from the Ministry of Health (Region), National Assistance Board (Local), County Council and the Old People's Welfare Committee, it was generally agreed that more could be done for old people by co-ordinating the work of the various authorities, bodies and organisations responsible for, and/or interested in, their welfare, and as County Welfare Officer, I have undertaken to arrange, from time to time, meetings of officers of the various bodies mentioned to consider individual cases which present real difficulties, and perhaps advise on broad lines of policy.

Welfare Services for the Blind, Deaf and Dumb, etc.

During the year the agency arrangements with

(a) the Cumberland and Westmorland Home and Workshops for the Blind;

(b) the Barrow, Furness and Westmorland Society for the Blind; and

(c) the Carlisle Diocesan Association for the Deaf and Dumb;

have been continued without any major issue arising which would call for detailed comment in supplementation of the comprehensive details given in previous reports.

(a) *Blind.*

Taking into account new admissions to the register, de-certifications, removal and deaths, the number of registered blind persons in the Administrative County shows an increase of 12 during the year under review. Actually the number of new admissions to the register was 67. The total number of blind persons registered on the 31st March, 1954, was 464.

In addition to the above, there are 51 persons registered as partially sighted.

Day to day administration by the Council's agents proceeds on well defined lines and much help and advice continues to be given to the voluntary committees on matters of general administration and individual problems.

The erection of new workshops at Petteril Bank, Carlisle, is under way, but it cannot be said when the same will be ready to go into production.

The Cumberland and Westmorland Home and Workshops for the Blind also acts as agents to the Carlisle County Borough Council and, as will be seen from the attached report, which gives a picture of the organisation and service as a whole for that part of the geographical County covered by the agency arrangements, the welfare service provided for the blind is very comprehensive.

(b) *Deaf and Dumb.*

The Carlisle Diocesan Association for the Deaf and Dumb (affiliated to the National Institute for the Deaf) operates throughout the geographical Counties of Cumberland and Westmorland, the Furness area of the Lancashire County Council, and in the area of the County Borough of Barrow-in-Furness, and is the only Association in those areas providing a welfare service for deaf and dumb persons of all denominations. The Association has Institutes in Carlisle and Barrow, with Centres in Kendal and Workington, where the deaf and dumb may enjoy special services by means of finger spelling and gesture.

In the whole area on the 31st March, 1954, there were 252 deaf and dumb persons on the register distributed and classified as follows:—

Category.	Cumbd. C.C.	Westd. C.C.	Lancs. C.C.	Barrow C.B.C.	Carlisle C.B.C.	Total.
School age or under ...	14	6	2	7	11	40
In Institutions ...	2	3	0	0	0	5
In Mental Hospitals ...	5	0	2	1	1	9
In Full-time Employment	61	11	5	14	23	114
Married Women at Home .	17	3	3	5	11	39
Single Women at Home ...	9	2	3	3	0	17
Unemployed—Age ...	6	1	2	2	4	15
Unemployed—Infirmity ...	3	0	1	2	1	7
Unemployed ...	1	0	1	0	0	2
Private Means ...	0	0	0	1	3	4
TOTAL ...	118	26	19	35	54	252

During the twelve months under review, 947 visits have been made by members of the Association staff to deaf and dumb persons in the area. That number includes visits paid to the Deaf and Dumb in their homes, in hospitals and institutions, or at their places of employment, but does not include the many visits paid on behalf of the Deaf, to relatives, prospective employers, Insurance Offices, Labour Exchanges and other Public Offices, as found necessary during the course of general welfare work. This visiting often brings to light personal problems in the solution of which the visiting Missioner can offer advice and help.

One cannot stress too much the importance of this routine visiting, especially in the case of deaf and dumb people living in isolated and lonely places, when distances, travelling difficulties, old age or infirmity make it impossible to bring them together socially. Perhaps it is in this direction, more than any other, that the Association's work needs to be still further developed.

It is important that the officers of the Association should have full information regarding deaf children and get to know them and their people during their early years whilst they are still at school, and to this end visits have been paid to their homes, especially during school holidays when the children themselves could be seen. The deaf children in this district are sent away to special schools, and in later years the Association is their only link with each other. Wherever possible these children are brought together in the Association's Institutes or Social Centres during the Christmas season and entertained.

During the year under review there has been no unemployment worth mentioning. Here and there a temporary break between jobs, but no problem.

The Institutes in Carlisle and Barrow are in constant use and social meetings have been held regularly in Workington. The Toc H in Kendal have continued to place their rooms at the disposal of the Deaf there every second Saturday. Ordinary social club facilities include a canteen supper, and all the usual indoor games. Whist drives are a regular feature, and the T.V. sets in Barrow and Carlisle have proved their popularity, especially during the long nights in the winter months.

Of special importance are religious services for the deaf and dumb, who are prevented by their deafness from full participation in any other organised form of public worship, and severely handicapped by the poverty of their language attainment should they attempt the reading of the Scriptures without assistance. Many, if not most, of the existing welfare organisations for the deaf and dumb were originally founded primarily to provide these special services, and all are today concerned to see that Christian precepts are brought to the Deaf and Dumb in a way they can understand. The Association has provided such services in its chapels in Carlisle and Barrow, and regular services have been conducted in both Workington and Kendal throughout the period under review.

It has not as yet been possible to fill the vacancy for an Assistant Missioner to be employed chiefly in the West Cumberland area. This post has been widely advertised nationally, in "The Deaf News," and by repeated circular letters to the staffs of other organisations, but no suitable application has yet been received. Other welfare societies are faced with the same problem, which seems to be a national one, caused by (1) suspension of normal recruitment of trainees during the war years, and (2) a greatly increased demand for these workers following the implementation of the National Assistance Act by the local authorities. Every effort will be made to appoint a suitable person at the first opportunity.

The Association is fully alive to all problems which beset deaf and dumb people and, notwithstanding a staff shortage (see previous paragraph) which is a handicap to a continuous service, let alone development and expansion, one can continue to compliment the Association on the standard of its existing services.

(c) Other Handicapped Persons

A scheme has been made by the County Council for the exercise of their functions with respect to the provision of welfare services under Sections 29 and 30 of the Act for handicapped persons, other than the blind, partially sighted, and deaf or dumb. The scheme, which has been approved by the Minister of

Health without modification, comes into force on the 17th June, 1954, and the Council's functions under Section 29, including the powers conferred on them in pursuance of Section 30(1) of the Act, fall to be now exercised in accordance with the scheme as approved.

The scheme is very comprehensive, provides for a variety of services, and enables the Council to provide the services either directly themselves, or by the employment as their agent of any Voluntary Organisation.

The extent and importance of the scheme will be noted from the following abbreviated list of the more important services (mandatory and permissive) which are to be, or may be, afforded :—

(1) Assisting handicapped persons to overcome the effects of their disabilities, and to obtain any available general, preventive or remedial treatment which they may appear to require.

(2) Advice and guidance on personal problems and in connection with any services which appear available to them and of which they wish to take advantage.

(3) Encouragement to take part in activities of social centres, clubs or institutions, whether provided by the Council or otherwise.

(4) Visiting by voluntary workers to help in the solution of domestic problems, and by accompanying handicapped persons to places of worship, social centres, clubs and similar places of recreation.

(5) Provision of practical assistance in their homes, lectures, games, library services, travelling, holidays and other recreational facilities.

(6) Sheltered employment in Workshops (utilising any special Workshops which may have been provided for the blind) and the payment of reasonable remuneration to persons so employed.

(7) Employment in open industry (in consultation with Ministry of Labour and National Service).

(8) Home employment.

(9) Handicrafts, crafts and other skilled activities, including training facilities.

(10) Marketing of produce.

(11) Hostels, social centres and holiday homes.

The first requirement of this new scheme will be to ascertain the existence of, and the needs of, the handicapped persons concerned, and this will be done

in due course by bringing to their notice (through press advertisements and via the machinery of National, Local Authority and Voluntary Organisations, medical practitioners, clergy and other interested persons) short details of the new scheme.

In association with the above will be the preparation of a register to be known as the "Register of Handicapped persons (General Classes)" which will give to the Welfare Committee more detail of the number of persons involved, and the size of the problem. Hereon it may be said that, to implement the scheme, additional financial provision will have to be made in the Committee's estimates for 1955/56.

RECEPTION CENTRES

PERSONS WITHOUT A SETTLED WAY OF LIVING

The Act imposed a duty on the National Assistance Board to make provision whereby persons without a settled way of living may be influenced to lead a more settled life, and to provide and maintain centres to be known as "Reception Centres" for the provision of temporary board and lodging for such persons. The Act also empowered the Board to require County and County Borough Councils to exercise on behalf of and in accordance with directions given by the Board, the functions of the Board of providing and maintaining reception centres, subject to reimbursement by the Board of approved expenditure by local authorities in carrying out this agency duty.

In the administrative county there is now only one reception centre which is at Station View House, Penrith, an establishment providing Part III accommodation and treatment for a number of chronic sick patients, together with a Maternity Unit (R.H.B.) The centre at Meadow View House, Whitehaven, was closed on the 1st March, 1949, and has not been re-opened, although there is an understanding with the Board that if wayfarers turn up at Whitehaven and it is not possible by way of public transport to get them to the nearest open centre, they are given accommodation for the night.

The functions of the Board in this matter have been carried out by the County Council since 5th July, 1948, and the following table shows the number of wayfarers provided with temporary board and lodging, and the extent to which the number has gradually increased quarter by quarter :—

	Penrith				Whitehaven			
Quarter ended	M.	W.	Ch.	Total	M.	W.	Ch.	Total
30/9/48	221	6	—	227	48	2	—	50
31/12/48	255	16	—	271	60	4	—	64
31/3/49	336	6	—	342	44	—	—	44
30/6/49	398	17	—	415	24	3	4	31
30/9/49	453	16	—	469	17	—	—	17
31/12/49	456	24	—	480	7	—	—	7
31/3/50	515	17	4	536	6	—	—	6
30/6/50	627	28	—	655	9	—	—	9
30/9/50	686	20	1	707	6	—	—	6
31/12/50	542	15	—	557	8	—	—	8
31/3/51	548	27	3	578	5	2	1	8
30/6/51	626	27	2	655	5	—	—	5
30/9/51	695	31	2	728	—	2	—	2
31/12/51	687	43	—	730	1	—	—	1
31/3/52	686	43	2	731	—	—	—	—
30/6/52	850	28	—	878	2	2	—	4
30/9/52	866	26	1	893	—	1	—	1
31/12/52	748	50	—	798	—	—	—	—
31/3/53	873	31	—	904	—	—	—	—
30/6/53	968	37	1	1006	—	2	—	2
30/9/53	903	35	2	940	1	2	1	4
31/12/53	722	27	—	749	2	—	—	2
31/3/54	738	30	2	770	—	—	—	—

From time to time strong and justified objections have been raised regarding the presence of casual wayfarers in and around the various sections of Station View House, Penrith (i.e., Part III, Hospital and Maternity) and the National Assistance Board were informed that the presence of such persons was not a good thing, either for the atmosphere of the hospital or the welfare sections, and that a continuance of the system could only have a detrimental effect on the standard and service of those establishments.

In my last report reference was made to a proposal I submitted to the Assistance Board in December, 1952, that having regard to the need for new Reception Centre accommodation in Carlisle, and the objection to the continued use of the existing inadequate accommodation at Station View House, Penrith, the use of

certain hutted buildings (Crown property) — the Merrythought Hostel, used as a prisoners-of-war camp and later as an agricultural hostel—on the main Penrith-Carlisle road, might well solve the problems of both the City and County authorities.

After a number of conferences and investigations on the spot, and the preparation, at no little expense of time and money, of plans and estimates of the probable cost of putting the huts into reasonable repair (including adaptations where necessary), an intimation was received in December, 1953, that the Assistance Board had agreed to proceed with the Scheme for Merrythought subject only to the examination of the proposals by the Ministry of Works, and that as the reference to the last mentioned Ministry would not take up very much time, the Board would be able to go ahead without further delay at a very early date.

That decision was received by the County Welfare Committee, the Carlisle City Council and the Special Area Committee of the Regional Hospital Board with considerable pleasure and relief, but disillusionment was soon to follow. In May, 1954, and after several efforts had been made via the Assistance Board to contact representatives of the Ministry of Works, to secure any necessary confirmation to the scheme of adaptations, etc., proceeding, the Board stated that the use of the Merrythought premises was under discussion with the Ministry of Labour and that obstacles, which appeared almost insuperable, were at the moment preventing any decision being reached.

On a request for information as to the nature of the obstacles, it was stated that the Merrythought site as a whole was regarded as indivisible, and that if it was acquired (as distinct from requisitioned) some use would have to be found for the remainder of the land and huts which would not be required for Reception Centre purposes. The problem is still under investigation.

After this lapse of time (18 months) the present position cannot but be regarded as most disappointing, and the Assistance Board have been asked for a final decision on the scheme at a very early date.

There the matter stands on the day of the conclusion of this section of the report (i.e., 28th July, 1954).

Civil Defence

Issues connected with Civil Defence, and in particular those relating to the welfare section, continue to receive considerable attention.

General Observations

During the year the general day to day administrative arrangements have proceeded smoothly, and collaboration established where necessary with the various Government Departments concerned, and other sections of the County administration, where services additional to those provided under the National Assistance Act could be invoked for the benefit of individuals concerned. Helpful advice continues to be given to many persons on issues completely outside the statutory duties of the County Council.

What has been set out above must not be taken as an exhaustive survey covering the whole field of activities of the Welfare Committee. This report merely touches upon some of those main features of the administration which it is thought would be a useful supplement to the County Medical Officer's Report for 1953.

W. C. WALKER,
County Welfare Officer.

APPENDIX

CUMBERLAND AND WESTMORLAND HOME AND WORKSHOPS FOR THE BLIND

Welfare Services, etc., for blind persons resident in the Administrative County of Cumberland and the City of Carlisle.

1 REGISTER

The number and classification of Blind Persons on the Register on the 31st March, 1954, was as follows :—

Age Group.	Males. City.	Males. County.	Females. City.	Females. County.	Total. City.	Total. County.
0— 5	—	—	—	1	—	1
5—10	—	2	1	1	1	3
11—15	2	2	2	—	4	2
16—20	1	1	1	4	2	5
21—30	2	5	3	5	5	10
31—39	5	13	6	10	11	23
40—49	1	15	5	11	6	26
50—59	3	30	6	25	9	55
60—64	4	15	2	21	6	36
65—69	7	16	9	31	16	47
70+						
Total	47	198	59	240	106	438

2 WORKSHOPS

(a) **Types of employment and numbers employed on the 31st March, 1954 (excluding trainees)**

Trade	Males City	Males Cnty	Females City	Females Cnty	Total City	Total Cnty
Agents and Collectors	—	—	—	—	—	—
Firewood Department	2	3	—	—	2	3
Bed and Mattress Making	1	3	1	—	2	3
Bedding Labourers	—	2	—	—	—	2
Brush Making	1	2	—	—	1	2
Basket Making and Rush Seating	2	2	—	—	2	2
Upholstery	—	1	—	—	—	1
Piano Tuning	—	1	—	—	—	1
Machine Knitters	—	—	3	3	3	3
Re-seating Chairs (in cane)	—	—	—	1	—	1
Total	6	14	4	4	10	18

General Observations on Employment

There have been no changes in the personnel of the workshops since the last report and all workers have been afforded full time employment.

(b) **Training**

Blind Persons at 31st March, 1954, receiving training with the approval and recognition of the Ministry of Labour:—

Training in.	Males.			Females.			Total.		
	City.	Cnty.	Others.	City.	Cnty.	Others.	City.	Cnty.	Others.
Brushes ...	—	—	1	—	—	—	—	1	1
Basket Making ..	—	—	1	—	—	—	—	1	1
Chair Seating ...	—	—	—	—	1	1	—	1	1
Total ...	—	—	2	—	1	1	—	1	3

General Observations on Training

Of the four trainees enumerated above the brush trainee has not been available for training during the whole of the period as the result of a skin complaint and a spell in hospital for an operation.

The trainee in basket-making from Kendal and the female trainee from Workington, undergoing a course of training in chair seating, continue to make satisfactory progress, although the chair seater is somewhat handicapped by a severe rheumatic condition in her hands.

The remaining trainee — from Gretna — also training in chair seating resumed her training early in the quarter following sick leave but is due for admission to hospital for an eye operation.

(c) **State of Workshops—adequacy of facilities**

The erection of the new workshops at Harraby is progressing satisfactorily, and the Committee of the Workshops is taking steps to equip the new premises with such new machinery and equipment as may be necessary.

(d) **Blind persons at 31st March, 1954, in Training at other recognised Centres**

Centre.	Training in.	Males.		Females.		Total.	
		City.	Cnty.	City.	Cnty.	City.	Cnty.
Yorkshire School for the Blind.	Machine Knitting	—	—	—	1	—	1
Newcastle	Machine Knitting and Cane Seating	—	—	1	—	1	—
North Regional Association for the Blind.	Home Teaching	—	—	—	1	—	1
	Total ...	—	—	1	2	1	2

Observations

The trainees shewn in the foregoing table remain as in previous reports but there are two further cases pending. The first a young woman of 21, a recently registered case in the County, at present undergoing a Rehabilitation Course at Torquay and the second a youth of 19, brother to the young woman mentioned above—is having further tuition through the Workington Grammar School in preparation for the examination for his General Certificate of Education to enable him to commence a course of training in Phsyiotherapy in December, 1954.

(e) **Blind Children in Special and other Schools at 31st March, 1954**

School.	Males		Females		Total	
	City	Cnty	City	Cnty	City	Cnty
Newcastle	—	1	—	—	—	1
Manchester	—	—	2	—	2	—
Chorley Wood	—	—	—	1	—	1
Prudhoe and Monkton Hospital	1	—	—	—	1	—
Fulwood, Preston	—	1	—	—	—	1
Royal Normal College	—	1	—	—	—	1
Yorkshire School for the Blind	—	1	—	—	—	1
Council Schools—						
Silloth	—	—	1	—	1	—
Brook Street, Carlisle	—	—	1	—	1	—
TOTAL	1	4	3	2	4	6

3 OPEN INDUSTRY

(a) **Types of employment and numbers employed at 31st March, 1954**

Trade	Males		Females		Total	
	City	Cnty	City	Cnty	City	Cnty
Factory Operatives	—	2	—	—	—	2
Labourers	1	5	—	—	1	5
Telephone Operators	1	2	—	—	1	2
School Teachers	—	—	1	—	1	—
Shop Assistants	—	—	—	—	—	—
Agricultural Workers	—	3	—	—	—	3
Physiotherapists	—	—	1	—	1	—
Poultry Farmers	—	4	—	—	—	4
Other open employment and St. Dunstaners not included above	1	4	1	—	2	4
TOTAL	3	20	3	—	6	20

(b) **General Observations**

A County case previously employed in a Maryport factory has had to give up work owing to ill-health, and a partially sighted youth formerly employed as a builder's labourer has changed his occupation to that of a factory labourer.
In addition to the table shewn there are two women in the County employed as part time office and factory cleaners respectively. All the remainder are in regular full time employment.

4 HOSTEL—PETTERIL BANK

(a) **Number of residents in Hostel on the 31st March, 1954.**
County cases, 8; City cases, nil; others, 2; total, 10

(b) **General Observations on maintenance, social activities and other matters of interest.**

During the year the Workers' Social Club which meets in the Hostel Recreation Room became members of the N.E. Games Association for the Blind and will compete in games or against teams drawn from similar clubs in other areas.

5 HOME EMPLOYMENT (not pastime workers)

On the 31st March, 1954, there were 5 Blind Persons in the Home Workers Scheme in the following occupations.

	Males.		Females		Total		Visits in
	City	Cnty	City	Cnty	City	Cnty	Quart'r
Braille Copyist	—	—	—	1	—	1	7
Piano Tuner	—	1	—	—	—	1	2
Farmer	—	1	—	—	—	1	2
Shop-keeper	—	1	—	—	—	1	14
Poultry Farmer	—	1	—	—	—	1	2

The number of Home Workers and the occupations followed remain as before. The Poultry Farmer, the last shewn on the Table above, has given up poultry-keeping altogether and is concentrating his efforts on pig farming.
The Braille Copyist on the list is always fully employed.

The Piano Tuner who is also a shop-keeper, continues to flourish, is well established in Whitehaven and can, with confidence, anticipate a good share of the piano tuning and repairing and radio and television business in the district.

The Farmer—number 3 on the list—is endeavouring to effect the necessary changes to enable him to have his cattle attested in accordance with recent regulations.

The returns of the shop-keeper—number 4 on the list—show little variation.

6 HOSPITALS, INSTITUTIONS AND HOSTELS (Other than Petteril Bank)

The number of Blind Persons in Hospitals, Institutions, Homes and Hostels, on 31st March, 1954, was as follows :—

Hospital, Institution or Hostel	Males		Females		Total	
	City	Cnty	City	Cnty	City	Cnty
Part III. Accommodation ...	1	10	3	4	4	14
Other Residential Homes ...	2	—	2	—	4	—
Mental Hospitals	3	2	2	2	5	4
Other Hospitals	—	—	2	2	2	2
TOTAL	6	12	9	8	15	20

In addition to the 35 cases there are three other blind people who are regularly visited—one from Westmorland; one from the North East Coast and another from Barnard Castle. To all these the Home Teachers have paid 73 visits during the quarter and taken a small personal gift at each visit.

7 HOME TEACHERS (At 31st March, 1954)

No. of Home Teachers in County area—4 + 1 part-time
„ „ „ „ „ City area 1
— Total 6

Districts & Home Teacher	Cert. or Uncert.	No. of Blind Pers'ns in District	No. of Home Visits during Quart'r	No. of other visits on behalf of Blind
City—				
Miss Speight	Cert.	106	147	38
Cumberland Rural Areas —				
Miss Fairhurst ...	„	90	146	24
Maryport and District—				
Miss Hetherington ...	„	89	258	26
Workington, Whitehaven and Districts—				
Mr. Hillard (males) ...	„	83	271	4
Miss Gander (females)	„	89	295	21
Mrs. E. Todd (very old folks)	Uncert.	87	445	7

During the quarter under review 1,682 visits were made to and on behalf of blind people on the Register and a further 997 personal contacts made at socials, handicraft classes, etc.

In addition to the foregoing, 131 visits and personal contacts have been made among those not eligible for the Register of the Blind but registered as Partially Sighted.

8 HANDICRAFT CLASSES

Location	No. of Class's held during quarter	Avge. Attendance	No. of lessons	Instruction given in	Instructor
Penrith ...	5	7	35	Basketry Pulp Cane Work	Miss Fairhurst
Cockermouth	8	6	46	Chair Caning Knitting	Miss Hetherington
Maryport	12	15	114	Weaving Rugs Stool seating	do.
Whitehaven	13	9	60	Embroidery Straw bags	Mr. Hilland & Miss Gander
Egremont ...	12	6	52	Netting Leathercraft Beadwork Crotchet work	Miss Gander.
Carlisle ...	10	9	97	String Bags.	Miss Speight

General Observations

There has been an addition to the handicraft classes since the last report by the establishment of a further centre at Egremont. The work, for beginners, is of a high standard and the interest and keenness of the members has already justified the formation of the class.

The Whitehaven class has been kept fully occupied producing trays, shopping bags, work baskets and stools. The quality of the work produced is worthy of mention when it is stated that the majority of the members are from 65 to 78 years of age.
The Maryport and Cockermouth classes are something quite different to the remainder—the Cockermouth contingent are "handicraft minded" whilst the Maryport members are more inclined to the social aspect—thus the more serious handicraft pupils from Maryport attend both classes and everybody is satisfied.

The City class held its New Year Party at the home of one of the members—the cost being borne out of class funds. Neighbours and friends supplied chairs and forms and arranged the refreshments.

A feature of the class during the quarter has been the making of rag mats. A dressmaker has supplied new clippings and the first two mats produced were promised to two young married women both members of the class who assisted in the work.

9 CLUBS

Social Clubs and Social Centres for Blind Persons are as follows :—

Location of Club	Open i.e. Daily, Weekly, Monthly, etc.	M/ship. (B.P.)	Av. Attend. (B.P.)	Short note on Activities.
Penrith ...	Monthly ...	16 ...	10 ...	See following notes.
Cockermouth ... (incl. Maryport).	,, ...	22 ...	18 ...	,, ,,
Whitehaven ...	Fortnightly ...	17 ...	14 ...	,, ,,
Workington ...	Weekly ...	54 ...	45 ...	,, ,,
Cleator Moor ...	Fortnightly ...	31 ...	20 ...	,, ,,
Carlisle ...	Monthly ...	25 ...	18 ...	,, ,,

General Observations and Report

The Penrith Club decided to hold a special event to celebrate the Coronation and organised a dinner followed by a party.

The Cockermouth Club continues to be very well supported with an average attendance of eighteen members. Entertainment comprising vocalists, orchestral music, talks and games organised by the Cockermouth Inner Wheel is of a high standard and greatly appreciated.

The Maryport Club meets each Thursday and the small band and singing sessions shew no loss of interest. Rehearsals are proceeding for the forthcoming Musical Festival.

The Whitehaven Club follows the same pattern as before, entertainment being interspersed with dominoes, party games and talks. The attendance remains at a steady average of 14 and the recently started "Savings Bank" enables members to save weekly and so provide themselves with extra pocket money for the approaching summer outings.

The Workington Club continues to be a live organisation with an average attendance of 45

who indulge in dancing, games, competitions, etc. Like Maryport the band and choir are preparing for the musical festival to take place later in the year. The Club at Cleator Moor with an average attendance of 20 follows a similar pattern to the Workington Club but as the majority of the members are quite elderly attendances fall considerably during the winter months.

Socials and Concerts have been held in Carlisle, whilst the annual Bulb Growing Competition, held in March, again attracted quite a large number of competitors.

10 BRAILLE AND MOON (Readers at 31st March, 1954)

	City.		County.	
	Braille.	Moon.	Braille.	Moon.
(a) No. of readers registered with the National Library (Northern Branch)	20	3	21	10
(b) No. of other readers	3	2	5	—
(c) No. of Blind Persons receiving lessons in Braille and/or Moon	—	—	5	4
(d) No. of lessons given during the quarter	—	—	18	15

11 WIRELESS SETS AND TALKING BOOKS

Three new wireless sets issued during the March quarter finished the 1953 allocation of new sets Further new sets from the 1954 allocation have been advised by the British "Wireless for the Blind" Fund and it is hoped to receive 60% of the original estimate of sets required for this period.

Twenty-two Talking Book Machines are in use in the City and County—eight the property of the Workshops for the Blind and fourteen privately owned.

Repairs have been carried out to two machines and the cost met out of the funds of the Workshops.
All users of Talking Books now deal direct with the Talking Book Library through the Home Teachers who assist in choosing and ordering books and attend to their return to the library after use.

13 HOME HELP SERVICE AND GENERAL MATTERS OF INTEREST

There are now 17 people receiving the benefits of the Home Help Service in the City and County as follows :—

2 in the City (registered as Blind Persons)
12 in the County (registered as Blind Persons)
3 in the County (registered as partially sighted)

The two City cases are both elderly people and the value of the service afforded by the Home Helps is beyond question.

Similarly, in the County, the Home Help Service has proved indispensable to those who have availed themselves of it. All are cleaner and better cared for than previously and one old man of 86 years of age is extraordinarily well cared for and could not possibly manage without the assistance so afforded.

Numbers of cases have been afforded assistance in cash and kind out of voluntary funds, especially those in hospital or in ill-health, and transport has been provided to socials and classes and where necessary for medical attention or examination.
A number of pensions for those not eligible for National Assistance have been obtained through the Metropolitan Society for the Blind and are paid regularly through the Voluntary Agency including a recent award of £30 per annum for an elderly blind woman in the City. Several blind ex-miners in Cumberland received through the National Coal Board, a small gift from a legacy left to blind ex-miners in Northumberland and Cumberland.